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ABSTRACT

The guide is intended to aid the integration of normally developing children and children with handicaps into one early childhood program. An introductory chapter describes the Northwest Center Infant and Toddler Development Program in Washington and chronicles initial philosophical, educational, and programatic considerations. Each subsequent chapter addresses major service components of the program: services to children in the integrated or mainstreamed program; methods for integrating; therapies in an integrated early childhood program; nursing services; home-based programming and nutrition services; family involvement; staff training; and transition procedures. Each component is examined in terms of rationale, service provision, suggested strategies for implementation, evaluation, budget considerations, and a reference list. (CL)

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THE INTEGRATION OF HANDICAPPED AND NON-HANDICAPPED INFANTS AND TODDLERS:

A GUIDE FOR PROGRAM DEVELOPMENT

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Northwest Center
Infant and Toddler Development Program

Linda Gil

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The following Staff persons have contributed to the refinement of this program throughout the past three years.

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INSTRUCTIONS AND EXPLANATIONS FOR THE USE OF THIS GUIDE

GENERAL

This guide is intended for use by for any persons or programs interested in integrating normally developing children and children with handicapping conditions into one early childhood program. The purpose of this guide does not include detailed instructions for designing and implememting a standard early childhood or child care program. That information is readily available to those programs with that goal in mind. The purpose of this guide is to provide the reader with major areas of concern and to detail some information about how this program addressed those concerns with specific reference to the integration of handicapped and normally developing children.

SPECIFIC

Except for the Introduction, each chapter begins with a rationale for why a major service componenet was chosen in this program. The methods for providing that service follows the rationale. Suggested strategies for implementation of the methods follow that section.

Following a discussion of the methods and strategies for providing each service, a discussion of the manner in which that particular component is evaluated in this program is presented.

Budget considerations that must be addressed before providing each service are discussed at the end of each

chapter.

At the end of each chapter (except for the Introduction) there is an outline of the five most important points that were included in the methods section. These are presented as a reminder of those issues that must receive close scrutiny if a program is to provide a particular service.

A reference list is provided at the end of each chapter for the reader's use in acquiring more information on the subject under discussion in each chapter.

Finally, each chapter is arranged in this manner in an attempt to present a useful and organized approach to the issues addressed.

TERMINOLOGY USED IN THIS GUIDE

Throughout the guide the use of the words "project" and "program" are used interchangeably with regard to Northwest Center's Infant and Toddler program. In the implementation stages, it was considered a project; then it developed into a program as it reached maturity.

In some chapters the words "educator" and "teacher" are used interchangeably.

The words used to describe persons in the parenting role are "parents" and "family." Occasionally the phrase "parent or caregiver" will appear in reference to the parent. The reason for the use of these words and phrases is that the primary caregivers in the lives of children in this program are not always the natural parents. Sometimes, temporarily or permanently, other persons become the primary caregiver of the child and continue to act in the parenting role. However, that term can be confused with educators or tea-

chers, so this program chooses to explain the people in the parenting roles as the child's parents and family.

The use of the words "he" and "she" is not intended to reflect any bias for persons in a particular role. The use of "he" and "she" is interchangeable and does not reflect the gender of the person in the description of roles and events.

FORMS AND PROGRAM MATERIALS

Not included in this guide are forms, program materials and products developed during the time this program was a demonstration project. The reason for this exclusion is that it is difficult to select the forms that might be useful to any program. Also, many forms are specific to this program. Finally, many forms would add to the bulk of this guide.

There are a number of products this program is willing to share with other programs. They include any forms developed for use with specific procedures, the vegetarian menu cycles, the Parenting Skills Guide for Mentally Handicapped Parents and a variety of items that might have some value for a program not already invested in particular forms and formats.

Inquiries can be sent to Program Director, 1600 W. Armory Way, Seattle, Wa., 98119.

Chapter I

INTRODUCTION

MODEL PROGRAM FOR INTEGRATION OF HANDICAPPED/NORMALLY DEVELOPING INFANTS AND TODDLERS IN A CHILD CARE SETTING

In 1980, Northwest Center Infant and Toddler Development Program commenced its first year of funding as a demonstration project. The purpose was to demonstrate the advantages of an integrated population of normally developing and handicapped infants and toddlers, ranging in ages from birth to three years. The program site is located in Seattle, Washington. This project was partially funded through the U.S. Department of Education, Handicapped Children's Early Education Program (HCEEP).

This project is a result of a documented need for full-day, out of home services for a population of infants and toddlers who are both handicapped and normally developing. Traditionally, working parents of handicapped children have not been addressed as a significant group with urgent needs for child care. In Washington State, a handicapped child who is in the birth to three years age range is traditionally served in early intervention programs at the University of Washington or community-based Early Intervention programs that are funded through the Division of Developmental Disabilities. While these programs are adequately serving some segments of the parent population with a handicapped child, working parents continue to be referred to Northwest Center. Originally, at Northwest Center, the program option was for six hours of daily

programming. As the parent's needs for a full day program were being addressed, and referrals continued to be directed to Northwest Center, another need was surfacing.

The need was for the staff of special educators and therapists in the program to have opportunities to focus on normal stages of growth and development in children. This seemed critical when providing educational and therapeutic activities to infants and toddlers with a wide range of handicapping conditions. This need emerged from informal conversation and experiences with other professionals in the field of Early Intervention. These profeessionals believed their services might be more effectively delivered in some form of integrated or mainstreamed setting.

Project parents also expressed the need for experiences with parents of other young children, both normally developing and with handicapping conditions. The original parents in this project indicated they did not want to be separated from other parents, as is often the case with parents of young handicapped children.

With the expressed needs of parents and staff for out-of-home care for infants and toddlers, the idea was formulated to develop a completely integrated, full-day program for working parents of both handicapped and normally developing children. This concept was presented in a written request for funds to support the development and operation of such a model.

The underlying philosophical issue was, and is, that children receiving care outside the home must be provided with the highest quality care to strengthen their skill acquisition at different developmental levels. This project's task was to develop and implement a mainstreamed/integrated full-day model that departed from a traditional approach to out-of-home care for young children with handicapping condi-

tions. An integrated child care program for children birth to 36 months of age did not exist in this city. The question of feasibility presented yet another reason for implementing a demonstration model.

Initial surveys of other childcare centers yielded but few centers in the Seattle area which were providing child care for infants and toddlers. No center provided full day child care with specialized educational and therapeutic services, delivered at one site and within a typical early childhood environment. The task appeared simple: design and implement a full day child care program, set in a typical early childhood environment, complete with specialized services and serving young children with special needs at any developmental level under 36 months of age.

The questions to be answered included: Who would be financially responsible? Who would enroll their normally developing child? What would be the desire to do this? What services would be provided? Who would provide them? How would the program know it was working and what would that mean? These were but a few of the questions posed by this process. The motivating factor was the desire by staff persons, community members and parents to provide parents of handicapped children with some of the same options and choices available to parents of other young children.

This manual chronicles the development of the project by indentifying some of the critical elements. Each chapter elucidates the information necessary for replication of such a component in an early childhood setting. This information can be adapted for a facility serving only handicapped children, or a facility serving normally developing children and wishing to mainstream children with handicapping conditions. This manual will not attempt instruction in implementation of a child care center, as there are publications available with such instructions. This guide's per-

spective is from that of a program wishing to provide an integrated or mainstreamed experience for their children. There will be an emphasis on the full-day child care arrangement because that is the nature of this project. This guide will read from the perspective of providing comprehensive services to young children with handicapping conditions and normally developing children in a full day child care setting.

Chapter I INTRODUCTION

PHILOSOPHICAL, EDUCATIONAL AND PROGRAMMATIC CONSIDERATIONS

Northwest Center's Infant and Toddler program identified early on the need for defining the educational philosophies on which the program would be based. This was necessary because this decision influences the overall program design, the choice of program objectives, the staff to be hired, the materials to be purchased and the evaluation strategies to be used. Eventually these decisions influence the interaction with children and parents.

The philosophical decision reached by this program regarding parents and children was to accept parents at whatever level indicated by their parenting style, emotional adjustment, cultural differences and child development information. The program philosophy was to move with them at their individual paces and to provide them with the information that would assist them in their parenting process. The same consideration was given to the children. One overall goal was to equip parents with useful information for problem solving and advocating for their child in programs in which they might find themselves upon leaving Northwest Center. For the children, the overall goal was to maximize their potential regardless of handicapping condition. This philosophical approach to parents and children included normally developing children as well as those with handicapping conditions.

This project chose as its educational approach the cognitive-developmental perspective based upon the research and information of the developmental psychologist, Jean Piaget. His observations and subsequent writings suggest that biological development is a process of adaptation to the environment and could not be explained by maturation alone. He describes cognitive acts as organization and

adaptation to the perceived environment. He asserts that the general course of development of intellectual structures is the same in all persons (Wadsworth, 1971).

Piaget's key ideas about how children grow intellectually are that their mental structures are different from adults, that mental development progresses through definite stages in fixed sequences and that children move through those sequences at different ages and stages of development. Further, mental development is affected by maturation, experience, social interaction and equilibration (Charles, 1974). The periods of development are described as the sensori-motor period, 0-24 months; preoperational period, 24 months to 7 years; concrete operations period, 7 to 11 years and formal operations, 11 years forward.

This project, serving young children chronologically birth to three years, focuses on the sensorimotor and preoperational periods. The child is viewed as an active participant in the environment, rather than a passive receiver of information (Bronfenbrenner, 1979). This has significant implications for the handicapped child. This cognitive-developmental approach provides all children the opportunity to act upon their environment and to have some impact on it, at whatever stage of their mental or physical development.

In this program, all of the child's skill areas are focused on for purposes of addressing the whole child. The skill areas include gross and fine motor, social, communication, cognitive, communication and self help. As identified by Uzigiris and Hunt (1978), the cognitive level influences development of the child at all stages in the skill areas. Borrowing from Bronfenbrenner's ecological perspective of development, this program concludes the following: intervention and learning most readily occur within situations that are a part of everyday, real life experiences encountered between infants and toddlers and their caregivers in such

settings. The child-care environment, where children spend much of their daily activities with adults and other children who are alike and different in many ways, is such a setting.

Consistent with the research of Carl Dunst as described in Infant Learning, this program chose to assemble the information into a cognitive-developmental approach. The judgment was made that such an approach would be appropriate to both populations being served in this program. This approach provides parents and caregivers with the information about stages of development. It prepares them with information about what happens at each stage before a child can progress to another stage. It maximizes the strengths of the child, regardless of the stage of development.

With regard to programmatic considerations, the cognitive-developmental approach influences the design of the environment and arrangement of materials, as well as the staff who work with the children. In this educational approach, it is assumed that children learn by manipulating objects, interacting with objects and people and being provided rich and varied experiences. That means materials and significant persons need to be accessible and available to all children, not just those who appear more able. The staff persons, from educators to therapists, need to understand how children learn and facilitate such learning in the environment.

This approach needs to be thoroughly understood by staff so that as information is conveyed to parents they can have an understanding of how it fits with what they desire for their child. The project staff found it necessary to be able to articulate the program and educational philosophy to parents and other professionals. In this way, there was a framework for understanding why certain activities were provided for their child.

For the staff, articulating the program and educational philosophy had a positive effect on parents. They had to take responsibility for choosing the program with a particular philosophy and its effect on the activities in which their child would be engaged. Frequently, as both normally developing children and children with handicapping conditions entered the program, the parent would disclose a concern about activities. The staff person would explain and give a rationale as it related to the program philosophy. The parent would have to think about the philosophy and activities as they related to their own desires for their child. Often times, for the staff persons, being able to articulate the program philosophy eliminated ambivalence in their own decision making. They did not have to quickly justify why they assumed a certain position on a particular issue. They could say the chosen activities fit with the overall program or educational philosophy.

The ability of staff persons to relate their actions to a particular philosophical framework allows them to question their actions, while at the same time being comforted in the knowledge that there was fundamentally a reason for selecting particular teaching or therapy strategies. The experience of this project is that neither parents of children with handicapping conditions nor parents of normally developing children of a very young age are clear about what their child rearing or parenting philosophy will be. The staff accepted responsibility in making a conscious effort to assist parents in identifying and articulating their own philosophies and practices. They made a conscious effort to assist them in understanding why this was important in the educational process of their child.

In summary, this project supports a recommendation, particularly in an integrated or mainstreamed program, that the staff be able to articulate the program philosophy. For the benefit of the child, family and staff, it is important that

the educational philosophy reflect a framework into which individual teaching styles, therapies, parent involvement and curriculum selection can mesh to form a cohesive and comprehensive service delivery system.

Chapter I INTRODUCTION

MAINSTREAMING -- THE OVERALL VIEW

For purposes of this guide, the term integrated is used (Guralnick, 1978) to describe the program and activities at Northwest Center. From this perspective, Northwest Center's program for handicapped children was integrated with normally developing children, creating a unique infant program in an early childhood setting. In this program's view, integration occurs when normally developing children are included with handicapped children and mainstreaming occurs when some handicapped children are placed in a usual group of normally developing children. Northwest Center's program has an equal match of normally developing and handicapped children, hence, the integrated program.

Kaufman, Gottlieb, Agard, and Kukic (1975) suggest the following definition of mainstreaming: mainstreaming refers to the temporal, instructional and social integration of eligible exceptional children with normal peers based on an ongoing, individually determined, educational planning and programming process and requires clarification of responsibility among regular and special educational administrative, instructional and supportive personnel (p. 30).

Diane Bricker (1978) shares her analysis that educational mainstreaming is undergirded by three classes of arguments and those are, social-ethicial, legal-legislative, and psychological-educational. Though these bases for integration are surely interrelated, there are other considerations. The philosophical consideration for the court decisions originating from the 1954 Brown decision suggested that separate was not equal and that forced isolation of any group of human beings deprives them of their inherent rights. Central to this consideration is the doctrine of least restrictive environment. These considerations were combined to form the basis for PL 94-142, the federal "Edu-

cation for All Act." These same considerations have been primarily directed toward the school age population, and not necessarily young pre-school children, and almost never handicapped children under three years of age.

The word mainstreaming is loaded with many different meanings for most people. For purposes of this guide, mainstreaming means providing experiences most likely to ensure that handicapped children maximize their potential for independent functioning at every level of their development. It is the pursuit of the most normal environment possible. This is achieved through bringing together handicapped and normally developing children. Appropriate education is unique to the individual child.

Regular preschool programs are outside of public schools in most states. Head Start was first mandated to serve 10% handicapped children in 1973. Most states do not have mandated services for handicapped children below the age of five years. It is usually permissive for public schools to provide services to young children with special needs. Usually the children most often identified for mainstreaming have been more mildly handicapped.

In the last decade, through Handicapped Children's Early Education Programs, younger children have been focused on through early intervention programs. These programs have been mostly categorical and therefore not mainstreamed. In 1978, the book Early Identification and the Integration of Handicapped and Nonhandicapped Children (Guralnick) appeared and systematically identified the influencing factors in integrated efforts. While this book was a landmark for identifying strategies to integrate preschool programs, there continues to be a dearth of literature on integrating children below the age of three years.

Chapter I INTRODUCTION

Mainstreaming, simply stated, is including children with special needs and children with usual needs together in the regular classroom. The goal of mainstreaming is to provide a favorable and normalized environment for children with special needs and to do it in the least restrictive environment possible. The fundamental assumption is that all children differ in their learning styles, interests, skills, and backgrounds and can benefit from an individualized approach. These experiences can help all children to live their lives more fully (Meisels,1977).

Within the spirit described above, Northwest Center's Infant and Toddler Program chose to identify with the explanation of mainstreaming and to integrate normally developing and handicapped children under the age of three years. The individual approach for parents of children was determined to be of value and could be accomplished in the mainstreamed environment. Mainstreaming appeared to be the most valuable approach in providing appropriate services to children with handicapping conditions and to those who were normally developing and under the age of three years.

GENERAL COMMUNITY BENEFITS OF AN INTEGRATED INFANT AND TODDLER PROGRAM

Since the mid 1970's there have been attempts to integrate very young handicapped and normally developing children in early intervention programs (LeLaurin, 1980 and ENCOR, 1973). These programs have provided some information regarding their components and methods of service.

There is a body of literature concerning integration and mainstreaming (see reference list in Methods for Integrating chapter). That information usually focuses on children who are ages 3-5 years. Little information is available in the professional literature relating to the integration of children under 3 years. There is considerable information available about infants and infant development, early intervention with infants, and parents and infants. There are manuals In the child care literature to be used as guidelines for developing a child care program, but none available with information in designing and implementing an integrated infant and toddler program.

Infant and toddler centers are relatively new to most communities. Although community based programs have been serving children 2 1/2 through 5 years in child care programs, the provision of such services to infants and toddlers in center-based programs is relatively recent. There is little information about how handicapped infants and toddlers might be served in a community based child care program.

In the urban area of Seattle, Washington, the need for infant and toddler care for normally developing childrn has been increasing steadily for 5 years (based on statistics of Children, Youth and Families Department). The need for child care for children with handicapping conditions who are also infants and toddlers has never been documented in a

formal manner. The Division of Developmental Disabilities has no such information.

Northwest Center's integrated infant and toddler program provides a unique model for how to develop an integrated or mainstreamed environment for this population. Over the past 3 years a guest book has been maintained that records visitors to the program. This number of visitors now exceeds 1000 persons. Program personnel are frequently requested to visit other programs, to speak about the program or provide consultation to other programs.

This model enhances the child care community in this city. It provides information to parents about the quality of services that children need in out-of-home care. It provides professionals in the child-care community with techniques for providing appropriate services through individual programming for all children. For the entire community, this model demonstrates that children who have handicapping conditions and children who are normally developing can, and do, learn satisfactorily in the same rich environment. This model demonstrates that children and families do not need to be segregated from one another based upon handicapping conditionn of the child and needs of parents. All children and parents need nurturing and supportive environments within which to flourish and grow as individuals and family members. The integrated child care center provides such an environment.

GOALS AND OBJECTIVES OF NORTHWEST CENTER'S INFANT AND TODDLER PROGRAM

The major program goals remain the same as they were three years ago. They are summarized in the following statements.

(1) To provide an integrated full-day, child-care program that includes normally developing and handicapped children under the age of 3 years.

(2) To provide an individual program plan for each child that includes attention to the following areas of development: gross motor, fine motor, cognitive, social/emotional, communication and functional self help.

(3) The development of a comprehensive and multidisciplinary educational approach to providing services for children with handicapping conditions and their families.

(4) To provide appropriate assessments and therapies for children identified as needing those services.

(5) To provide parent involvement and educational opportunities for all those assuming parenting responsibilities for the child.

(6) The provision of an individual health maintenance plan for each child to be monitored by a nurse and coordinated with the child's primary health care provider.

(7) The provision of a sound nutrition program for each child in the center.

(8) To provide a staff training plan to insure the professional growth and development of each staff person.

(9) The provision of transition procedures and information to families when it is time for their child to leave this program.

A description of the implementation of these goals is included as a part of the discussion in each chapter. They were identified in the original proposal and are as relevant today as they were three years ago. All that has changed is a refinement of the methods for providing these services.

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Chapter II

SERVICES TO CHILDREN IN THE INTEGRATED OR MAINSTREAMED PROGRAM

The description of services to children will include those services offered to both populations of children in Northwest Center's integrated program. The focus of this chapter will be on the rationale, methods, and strategies used in identifying and providing services in a program serving both children who have handicapping conditions and those who are normally developing. This chapter will focus on the services provided for the children while succeeding chapters will focus on the inter-relatedness of staff roles, ratios and parent involvement in those services.

RATIONALE

The purpose of integrating normally developing children into a program serving handicapped children is to provide a more normal environment for all children receiving services from a public agency (McGlaughlin, Kershner, 1977). The full day services were offered initially because parents of both populations needed a full day care program outside of the home. Both parent populations have similar needs for child care, including a quality early childhood setting, accessibility of those services, convenient hours, trained staff to provide those services and a method of accountability for those services. In addition, children with handicapping conditions need a comprehensive program that includes therapies to address the handicapping condition, assessments of the child that lead to a specialized educational program,

and some special attention to how that will all occur in the full day setting. Parents need to be involved with their child in a special way that is reflective and supportive of their choice to work outside of the home.

Northwest Center's role is to be a support system and to be an adjunct to the family system. The Center chose to provide support through establishing routine procedures based upon what parents indicated they wanted, establishing a communication system in which all could understand and participate, focusing on comprehensive child services, remaining flexible with time problems of working parents and always striving to provide an individual family program plan. This means being sensitive to the changing needs of the child and the family unit.

Chapter II SERVICES TO CHILDREN

METHODS OF SERVICE

In this program, services to children include a 12 month and full day child care arrangement. Length of day is optional to parents and based upon the needs of the child and the family. Comprehensive services include the following: child assessments at least three times a year and subsequent written reporting for all children, occupational, physical and speech assessments and therapies for handicapped children; a home based program for those handicapped children for whom it is more appropriate and whose parents desire such a program; developmentally appropriate activities provided by trained personnel throughout the child's day; and multidisciplinary staffing by the center staff and parents to determine how those services can be most effectively delivered to each child.

Parent involvement activities are varied and available in every component of service to the child. These can include conversation when arriving and leaving, writing daily in the child's notebook, formal participation in conferences and therapy sessions, evening parent meetings and a host of opportunities that will be described in the parent involvement chapter.

The challenge was and continues to be to integrate all of the child and parent activities into a quality early childhood environment where activities and practices are applicable and adaptable to all children in that environment.

In this center, the licensed capacity is established at no more than 48 children and includes the ages 4 months to 40 months. The children served in the home based program can be served from birth. Twenty-four of these children are normally developing and 24 have handicapping conditions, ranging from a mild delay in a skill area to multiple

handicaps. The decision regarding grouping of in-center children was a critical one. Descriptions of groupings from two sources, Early Child Care (Chandler, Lourie and Peters, 1968) and Early Intervention and the Integration of Handicapped and Non-handicapped Children (Guralnick, 1978), and the experience of the project director in other early childhood programs were instrumental in defining and implementing the group composition. The program chose to call these small units of children "family units" and a description of them is as follows:

Explanation of Family Unit Groupings

Infants and toddlers served in a full day setting have common needs. These needs include consistent care givers, a nurturing environment, understanding of developmental levels, appropriate activities, attention to a reasonable routine in their daily experience and the opportunity to have these needs met with as little competition from other children as possible. Children need to build feelings of confidence through exploration within defined boundaries in an environment that encourages movement from one developmental stage to another.

The Northwest Center program seeks to provide an environment that will accommodate children's needs. The concept of "developmentally integrated groups" is based upon descriptions of groupings in the literature where younger and older peers interact with each other in the environment (Guralnick, 1978). Another consideration is that families are composed of people at differing levels of development from which all learn and that the family structure constitutes a valuable and nurturing environments for the developing child (Lewis & Rosenblum, 1974, and Satir, 1972, 1973). Since a child in a full day program may spend a large portion of her time with peers in a child centered environment, it is

appropriate to create an environment consistent with the family structure. The child's classmates, who are at differing levels of development, then become the "siblings" in the "family unit." This grouping supports the view that all members of the group learn from one another. The child with a handicapping condition is viewed as a member of the "family", with the handicapping condition being but an aspect of development and not the primary focus of attention.

In this program, with 48 children, there are 6 family unit groupings. Each family unit has 8 children; 4 who are handicapped and 4 who are normally developing. Within this grouping, two children will be at the infant stage of development (cognitively 12 months and below), two or three at the toddler stage of development (cognitively 24 months or below) and two or three at the preschool stage of development (cognitively beyond 24 months). In this grouping, a child with a handicapping condition that places that child at the infant stage of development and a normally developing child become the pair at the infant stage of development. The same occurs at the toddler and preschool levels. The intent is to provide a view of developmental stages that are represented on the continuum of development from birth to 3 1/2 years of age.

The benefits to the child in this grouping are measured by child change on individual programs, comparison child change scores in the developmentally integrated groups with change scores in the peer groups (discussed later in text), and evaluation provided by parents regarding their child's participation in the groupings. These child change data are documented over a 10 month time period.

More importantly, the child benefits appear to be: reduced competition for materials in the environment because of children using materials differently at each stage of development; reduced competition for adult attention because at

each stage the child vies for adult attention in a different manner; engaging in positive behaviors and activities modeled by older or more capable children; expressed sensitivity to the needs of each member of the small group; increased independent problem solving with other members of the "family group"; and a bonding with that small group of persons within the context of the center's larger group of adults and children.

Equally important is the evaluation of staff and parents that the staff prefer working with the developmentally integrated group because they feel they can relate to the individual needs of the child in a more relaxed, confident and interested manner. They are finding reinforcement in working with children at different levels because they are not constantly required to meet the needs represented each day by 8 children who might be at the same level of skills and development. This also assists the staff in viewing each child's development on a continuum, rather than focusing on only one stage of development or category of handicapping condition.

STRATEGIES

All children enrolled in this program receive the following services:

(1) **Placement** in a family unit group of eight children, four with handicapping conditions and four who are normally developing. The family units are also developmentally integrated, with representation of stages of development from four to 40 months. The family units are staffed by two teachers, an early childhood educator and a special educator. They are the case managers for each family group. Assignment to the group is the responsibility of multidisciplinary team.

(2) **Initial** and ongoing assessments are provided to all children in each group. Only children with handicapping conditions are assessed by the multidisciplinary team (nurse, therapists, social worker, and educators). Each child is required to have a complete physical examination administered by his or her primary health care provider before being admitted to the program. The multidisciplinary team reviews the records of each handicapped child to determine if further information is needed (i.e. psychological, nutrition). The nurse assesses the health information of the normally developing child. Rarely is there a reason to suggest to parents any further assessment of a normally developing child. However, because the nurse monitors all health records and the educators monitor all evaluations and program plans, any concern is noted and appropriately referred for evaluation.

After initial assessments have been completed, formal conferences conducted with parents (or significant caregiver) and a determination of goals has been made,

an Individual Educational Plan (IEP) is written for every child. This plan includes expected developmental changes, a plan by which this will occur, who will be responsible, when changes are expected to occur and how they will be measured and monitored. The plan is projected onto a 10 month timeline. The individual plan includes the use of behavioral statements for purposes of objective data collection and analysis of the changes. The program plan is intended as a written guide of development for educators and parents and a strategy for managing the growth and developmental changes of the child. It includes goals and objectives in all skill areas (i.e. gross/fine motor, communication, self-help, social emotional, cognitive) and a projection of how each child will move from the initial assessment point to a projected point in their development in each area.

(3) **All parents** receive regularly scheduled written classroom narratives which describe their child's progress in all skill areas. Similarly, when appropriate, therapy reports accompany these narratives. The program plans are reviewed and revised twice yearly and parent conferences occur for the purposes of discussing the change data and the progress of the individual child. These reports are valuable information and useful not only to parents but to the programs where children attend when leaving this program.

(4) **Peer group** experiences occur twice weekly for a period of 1 1/2 hours. Informal cognitive assessment with the Uzgiris-Hunt Ordinal Scales of Psychological Development in Infancy administered by the Communication Disorder Specialist (CDS), provides the basis for an assignment to a peer group. In these groups, children are at the same stages of cognitive development as their peers. Criteria, representative of Piaget's

description of the 6 stages of cognitive development in the sensorimotor period to the preoperational period, have been established for purposes of the child moving from one group to another. Generally there are groups representing the 0-4 months range, 4-8 months range, 8-12 months, 12-18 months, 18-24 months and 24-30 months. Sometimes, at the end of the year and before time for children to leave to attend other programs, a group is formed that is comprised of children cognitively above 30 months. Usually the participants are 1 or 2 handicapped children and 3 or 4 normally developing children.

The purposes of the peer groups are to observe children interacting with each other in groups other than their developmentally integrated family unit groupings; to provide them a structured time to be with cognitively same level peers; to explore concepts that are specific to the cognitive age ranges represented in the levels described; to formally focus on a group at a particular stage of development and to observe the handicapped child and the normally developing child in these particular arrangements. In these groups, the curriculum in use is the High Scope Curriculum, by David Weikart, from Ypsilanti, Michigan.

(5) **Nutritional Component.** Semi-annual screenings are provided to each child whose parents give their consent. The screening consists of a 48 hour recall of foods consumed in the home, coupled with the same period of in-center food consumption. Evaluation by a registered dietitian, accompanied by follow up information, resources, referrals and suggestions are made, in writing, to parents and when appropriate, to primary health care providers.

(6) **Health Screens.** Annual dental, vision, and auditory screenings are routinely provided to all children at the center, particularly if they have not had these screens administered within the previous year. Routine monitoring of immunizations and current health status is subsequently reported by the nurse to the primary health care providers. All health concerns are monitored by the nurse. Any collaborative information needed to complete the health history and current status of each child is acquired or arranged for by the nurse, who is given that responsibility by the multidisciplinary team.

(7) **Therapies.** For the child with handicapping conditions, pediatric trained occupational, physical, and communication disorder therapists provide appropriate services. If a child exhibits a delay in an area of gross or fine motor, self help, communication and cognition, the appropriate therapist evaluates the child's developmental level in that skill area. With the other members of the multidisciplinary team, the therapist establishes the therapy goals, designs the plan, including length of individual and group sessions, and coordinates the delivery of those services throughout the child's day. The intent is for the therapies to be delivered in the most naturalistic setting available to the child (i.e. feeding therapy occurs most naturally at meal times). The length of the full day program accentuates the opportunity to provide therapies in a most naturalistic environment, because there are more opportunities to do so than are found in establishing a therapy hour at a fixed time each week. If a child does not perform well during one time, there are other opportunities during the day and week.

(8) **Integrated Setting.** All children are provided services in a completely integrated setting throughout the day. The only exception is the 1:1 evaluation or therapy session in which a therapist or educator needs to focus on an aspect of the child apart from other children. These 1:1 or small group therapy sessions are at that time in the best interest of the child, who needs that attention because of the handicapping condition or because evaluation is best performed with an individual child, apart from other children and adults.

(9) **Home Based Programming.** For children with handicapping conditions, there is always the option for a home-based program that is provided by the Family Services Specialist (social worker with a background in education). For a variety of reasons, a parent may elect to have a home-based program or a combination in-center/home-based program provided their child. Most often, home-based services are provided to parents who are not working outside of the home. A consideration is always the appropriateness of the services for the child. Some determining criteria for home-based services are: health status of the child, specific parent needs, the availability of in-center spaces and concerns of any other agency working with that family. For example, if Child Welfare is working with a family and that agency's concerns are related to the child in the home, then that agency's perspective would also be taken into consideration. Determination of program placement is made by the Multidisciplinary team, which also includes the family.

Northwest Center Infant and Toddler Program seeks to provide comprehensive services in not only an integrated environment, but in a systematic manner that meets the needs of all participants.

The services just described are in response to the identified needs of the families and children who are a part of our program. Parents who work outside of the home, as a group, have unique needs over and above being a parent of an infant or toddler, and beyond that, the parenting of a child with a handicapping condition. One strong need is for the educational, therapy and health needs to be delivered at one site. Providing an environment in which these needs can be addressed reduces some of the stresses and concerns experienced by parents.

EVALUATION OF SERVICES TO CHILDREN COMPONENT

The following description of how this program evaluates its services to children is provided as a guideline for how other programs might choose to design a similar component. In the State of Washington, programs serving children with handicapping conditions under the age of 36 months and who receive monies from the State Division of Developmental Disabilities, must evaluate child changes and the effectiveness of their program. In the experience of this writer, programs providing services to normally developing children only do not typically document child change or program effectiveness. It is important for those programs considering mainstreaming a few handicapped children, or integrating normally developing children, to consider evaluation procedures as important as the services being provided. The benefits are to the staff who can confirm their own daily work, to the parents who experience the changes in their own lives and their child's performance, to the funding sources who can observe what their dollars are buying, to the legislators who appropriate the monies to make the services possible and not the least, to the children for whom it was all designed.

Generally speaking, if children with handicapping conditions are going to be a part of any program, some agency within state government is usually fiscally responsible (i.e. school district, private agency, institution). That designated agency usually requires some form of reporting child change and progress and the ability to document program performance. This means that a particular agency spending money on providing services to children must have some method already established for monitoring that evaluation process. That can mean there are personnel available to evaluate, to teach the evaluation format or at least to provide the training to staff so that individual members

might have skills to evaluate the overall program, child change, parent involvement and the effectiveness of the services.

In a child care program involving normally developing and handicapped children, the program will want to be responsible for accountability. This will mean evaluating the child and reporting the results to parents and whomever else is identified as significant in that child's life. The program will want to document that the child's needs are being met and that appropriate change is occurring. Parents of all children, and particularly handicapped children, will want to know how that is happening. From this program's experience, parents of normally developing children want to be able to observe the changes and receive some sort of documentation of the changes.

For the child care program with not much expertise or experience in the methods of recording child change, perhaps a therapist or social worker involved with the special needs child and who is coming into the center as a resource person, will be the responsible person to record those changes and write reports. This person can also train others in the methods. The reader need not assume that child change data cannot be included as a program procedure simply because no current staff member can manage all of the elements described in Northwest Center's evaluation.

Evaluation Design

In this program, the staff finds it useful to implement an evaluation design that provides a credible estimate of the no-treatment expectations. This program uses two quasi-experimental designs. A norm referenced design used with publishers norms for the Bayley Scales of Infant Development serves as the comparison group for assessing program ef-

fects. Additionally, this approach is augmented with a multiple baseline design where in each child's mastery of objectives in her individual plan is used as a measure of program effectiveness. In this arrangement, data are collected before treatment is initiated and each child acts as his/her own control. The number of skills mastered before treatment is compared to the number of skills mastered after treatment.

Each child is assessed using the norm referenced Bayley Scale of Infant Development (Bayley, 1969), a criterion referenced instrument (i.e. Developmental Programming for Infants and Young Children, 1981, or The Hawaii Early Learning Profile, 1979, or the Learning Accomplishment Profile, 1978, or the Rockford Infant Development Evaluation, 1979), and when appropriate a specific therapy instrument (Peabody Motor Scales, 1980 or Sequenced Inventory of Communication Development, 1975). The therapists are trained to use the Bayley and the specific therapy instruments pertinent to their domains, while the educators administer the developmental checklists. Information is then synthesized by the multidisciplinary team and the educators are primarily responsible for the writing of the educational plan. Input from other team members relate to task analyzing objectives, appropriateness of sequence of objectives and other pertinent information that will lead the child to attaining those chosen goals.

The parents work with the team, giving their ideas and suggestions to help formulate the plan. The same process occurs with children who are normally developing except that only the educators and parents are involved in the plan, not the therapists. Each child's program plan is a working document, a plan by which changes are monitored and recorded in the permanent record of the child. The objectives are behavioral statements with specific criteria attached so documentation of meeting the objective is as clear as pos-

sible to parents and staff. The educators and therapists record the changes on the written document that remains in the child's center file. These changes are written or verbally communicated to the parents so they might record these changes at home. Similarly, parents report any information to the team through their child's notebook that accompanies the child to the center each day.

In this program, five months after the initial assessment period, the reevaluation process begins. The number of skills the child has gained is measured against the Bayley norms, and the number of skills gained before intervention began is measured against the gain after focused effort. For the handicapped child, the raw score, as indicated on the Bayley, is reported in age equivalents. Formal parent conferences occur at this time for the purposes of reciprocal communication. Conferences include the parents and other significant persons or agencies. The written classroom narrative, therapy reports and updated individual program plan information are sent to the primary health care providers, parents, other agencies involved with the child (i.e. ancillary health care providers, funding sources).

For purposes of clarification, for the child who is normally developing, one developmental checklist and the Bayley scales are used for purposes of program planning. These measures are useful for acquainting the parents with the normal schedules of growth and development and to provide educators with a framework for providing an individual approach to the care of the normally developing child. In addition, these measures can provide a check on program effectiveness and a norm against which to evaluate all of the handicapped children's programs. Most importantly, for all parents, the individual plan answers the question, "what are you doing with my child during the day?" The plan provides the educators with more objective information for classroom planning and viewing the child as an individual

member of the group.

The next evaluation period occurs five months after the first reevaluation period. At this time, all measures are re-administered, changes recorded in the same manner as has been described and the child's individual program plan comes to closure at this time. For the children who have reached their third birthday by the local school district entrance date, this conference signals the end of their time in this program. With parents as a part of the multidisciplinary team, the program plan is signed, documentation indicates its completion and the transition procedures are initiated (to be described in the transition chapter). For children who are not yet three years of age before the school district date, they remain with Northwest Center for another year, and the same evaluation and planning process is implemented in September. Program plans are compared from one 10 month period to another. The 10 month time line is observed because evaluations encompass approximately 2 months of pre-during- and post-administrations. The program plan actually falls into 10 months of intervention strategies.

The developmental checklists mentioned in the previous paragraphs are but examples of instruments that are a part of the assessment protocol in this program (see reference list for examples of others). Each developmental checklist selects items from norm referenced instruments (i.e. Bayley) and attaches criteria to the task for the testor to apply, before scoring the child on that item. Each checklist has its own criteria for determining a basal and ceiling level. Each checklist chosen for a particular child is chosen based upon the the judgment of the educator. There are few developmental checklists particular to assessing a particular handicapping condition, so as each educator becomes familiar with a variety of instruments, the most appropriate ones are selected. For example, a checklist that includes more items in each skill area and breaks them into smaller increments

of performance is going to be more helpful in assessing a more severely involved child. For the child who is more mildly involved, or who is normally developing, a checklist with less items in each skill area can be as useful. The purpose, for the inclusion of several developmental checklists and norm referenced instruments in the protocol, is to yield information that provides the multidisciplinary team with a direction in which to move, with regard to the individual child's program plan. Because of the variety of handicapping conditions represented in Northwest Center's program, a wide variety of developmental checklists is used.

The pre/post testing information provides a measure of what occurred before, during and at the end of the intervention. Progress across time, for handicapped children, does not always show on tests like the Bayley. However, subtle changes are apparent on developmental checklists. Using several measures creates a more complete picture of of the child which helps in designing appropriate services to the individual child. Careful explanations of the drawbacks of each test is always part of conversation with each parent. This information is also important to communicate to funding sources for the handicapped child, as well as the ancillary personnel who might be involved with the child and family.

Evaluation Summary

From this program's perspective, it is an advantage for the staff working with both normally developing and handicapped children to possess good skills in child observation and assessment. Clear communication with parents and any other persons or agencies involved with the child is very important, especially in communicating information about the weak points of each evaluation instrument used with a child. This program's perspective is that objective evaluation for purposes of determining an individual approach with each

child is valuable for every child. The degree to which any program follows this model or these procedures depends upon the individual program goals, the staff available, skill level of the staff, resources to program and staff training plan.

For a staff person unfamiliar with some of these procedures or instruments, this description may seem overwhelming. The more staff become familiar with the child assessment protocol established in a program, the more useful the information becomes in planning for each child.

The range of services to children in the Northwest Center program is consistent with the overall program goal of providing comprehensive services at one site. This program is able to provide these services through a combination of staff hired to perform services, contractual arrangements, reciprocal agreements and donated services.

BUDGET CONSIDERATIONS

This program offers all the services previously described in this chapter. All the services are considered to be necessary to the children enrolled in the program. If a person could not be directly employed to provide any one of these services, or contracted to do so, or services purchased in some other manner, then the goal of providing comprehensive services would have to be reevaluated.

For example, the two educators who make up the team to provide educational services to the small "family unit" of eight children bring together the skills of a special educator and early childhood educator. Those skills include the technical training to perform assessments, write behavioral programs and develop specific teaching strategies. They also include the perspective on normal growth and development of the early childhood educator. Both perspectives are needed to provide the services to four normally developing and four handicapped children in one group and to maintain the 1:4 teacher/child ratio.

If this program had to reduce its budget or alter it, the administrator would have the options of changing the ratios or reducing the staff of special educators, who usually cost more. This could lead to a change in comprehensive services. The special educator's role could become more a resource to other staff persons than direct teaching. Although this arrangement could still have the effect of meeting program goals of assessment and individual child program planning, the time spent on assessing and length and type of reporting might be altered. That could mean a change in services provided, and a change in program goals.

The same budget considerations need to be made with regard to therapy, nutrition, nursing and other support services.

This program has been able to hire persons to provide those services. If, at some time, we cannot do this, we would look to a variety of purchase, loan, exchange or other methods for securing needed services. If necessary, the child's IEP would be changed to reflect a reduced capability to provide services. This program uses every available resource in the community. A program objective is that identified personnel, usually the program administrator, has the responsibility to be aware of all community funding sources and how to use them for services to children (i.e. psychological testing services, neurological evals).

Staff salaries account for approximately 75% of program expenses. This is the cost of providing direct and comprehensive services at one site. The other costs are program overhead, materials, maintenance, janitorial, facilities and the usual costs any program incurs as a process of operation. The funding sources for staff salaries are provided in a variety of ways, including the State Division of Developmental Disabilities (25%), Title 1 monies (10%), parent fees for normally developing children (30%), private donations (10%) and the agency's investment in its own program (25%) through fund raising efforts. This program is one component of a larger non-profit agency, so our financial security is always dependent of the solvency of the agency.

Services to children with handicapping conditions are supported in part by the State Division of Developmental Disabilities. This program is paid a fixed dollar amount for each day each child attends the program. That total amount the agency receives is calculated by multiplying the per child amount by the number of children to be served and the number of days. This amount is allocated to the agency through contracts with the state and county.

Parents of children who are normally developing pay a monthly fee. This program is searching for a sliding scale fee

approach, based upon income and ability to pay, for all parents in the months to come. To date, the parents of handicapped children pay nothing. Also in the future, research will be conducted to determine if insurance payments for therapies can be a small source of revenue for therapies provided. Thus far, those monies have not been secured because many parents belong to a group health cooperative, some are Medicare recipients which does not pay for such services, some have private insurance that does not cover therapies and for a variety of other reasons.

There are advantages to being a part of a larger agency, such as having clerical services that are provided -- accounting functions from the accounting office, fund raising by a particular department and other functions common to any non-profit agency. The disadvantage is not being able to use some financial sources that may be available to other agencies (i.e. United Way, Crippled Children Services, contracts with school districts). Each of these particular revenue producing sources has regualations and policies that prohibit Northwest Center from participating. Any agency considering replicating components of this program needs to consider carefully all revenue sources in their particular community. Having knowledge and access to information about revenue sources is absolutely critical for developing an integrated or mainstreamed child care program.

The intent of this budget consideration section is to convey more philosophical considerations than actual line items in the budget. The program services, their relation to goals and the financial considerations required to obtain and provide those services are important here. The process of negotiating for those services is undertaken only to the point where the program goal for services to children is compromised. At that point, the program goal and subsequent services would have to be modified to more accurately reflect the budgetary constraints to be accommodated.

Chapter II SERVICES TO CHILDREN

This program is committed to keeping present services to children intact, so every effort is made to secure financial support for such services. For this program and any program contemplating providing similar services, that means continually searching for new and more appropriate means of financial support.

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Chapter III

METHODS AND PROCEDURES FOR INTEGRATING OR MAINSTREAMING A PROGRAM

RATIONALE

The premise of this chapter is that a decision has been made to integrate or mainstream an existing early childhood program so as to better meet the individual needs of handicapped and normally developing children. Assumedly, staff and parents have made the decision to have an integrated program and all concerned are committed to the concept.

METHODS OF SERVICE

Northwest Center's Infant/Toddler Program was originally an early intervention program serving 24 handicapped children. When the federal grant was received, the task was to demonstrate an integrated format and to determine how others could be encouraged to do the same. Federal funds are not essential to the development of integreated or mainstreamed programs. The strategies which follow apply to anyone commited to the task of mainstreamed or integrated programming.

Two issues need to be clearly understood. It is important to have more than a basic understanding of the literature that relates to mainstreaming. First, when the path to program implementation is strewn with problems, the program staff needs to know that there is something more to support the integrated or mainstreamed concept other than someone's

"good idea". This project found this to be very necessary. It is important that the Project Director and all staff be well versed in the concept and familiar with the literature. If only a few persons have that information, the remainder of the staff need to acquire it in a systematic and timely manner.

Secondly, the commitment of the staff to the concept of mainstreaming is critically important. There were many frustrations during the first few months of this project. These included: expectations of a new set of parents, reporting assessments to parents of normally developing children, time management in a full day program including the subsequent paperwork, expectations of all the various funding agencies and most importantly, the lack of information available for comparing what we were doing with what others were doing. At that time, no such information was available. It would have been easier to return to the "safer and more comfortable" position of the program that was in existance before the integrated plan was implemented.

Only after the first 8 or 9 months could most staff members begin to see benefits for both staff, children and parents. Confidence in their own abilities to find the time to assess and plan in a full day environment and the experience of having both groups of children to observe the patterns of growth and development contributed to their growing satisfaction. Also, learning and experimenting with strategies for promoting interaction among children added to their feeling of contributing to an important accomplishment. They became more familiar with the literature about what does and does not work when providing services in an integrated environment. After almost two years, the staff could comfortably and knowledgably relate the positive aspects of an integrated program to any audience. Their enthusiasm increased when their theoretical knowledge was backed with practical experience. The staff began to know why and why

not they chose particular strategies and approaches in the classroom.

Combining the available information in the literature with a well designed program plan is an important strategy. From an article by Meisels, Young Children (1977), entitled "Steps to Consider when Mainstreaming", came useful guidelines to develop. Steps 1-12 are excerpted from the article and steps 13-19 are added by this project.

(1) Decide as a staff that you wish to explore a commitment to mainstreaming.

(2) Visit other mainstreamed programs as well as special class placements.

(3) Establish your internal support system. Critically analyze the skills and capabilities of your staff.

(4) Arrange for consultation.

(5) Establish criteria for intake and program guidelines.

(6) Meet with parents of children who are normally developing. Explain rationale again and again. The same needs to be done with parents of handicapped children, separately and as a whole group in the beginning stages.

(7) Obtain consent from your board and establish an advisory committee of parents and professionals.

(8) If possible, encourage staff to enroll in inservice courses or arrange for someone to come in for ongoing instruction.

(9) Make necessary spatial and environmental changes.

(10) Maintain contact with all resources.

(11) Keep the support systems operational. Mainstreaming requires attention to all children's needs.

(12) Keep asking questions.

In a program serving only normally developing children, in addition, consider the following:

(13) What is the chronological age of the child? This is an important consideration because it can determine the appropriate funding source, even though another agency may be providing the services (i.e. school district, health department, developmental disabilities).

(14) Confirm that some agency is responaible for continuing to seek and provide support services (i.e. therapies, special education assessment and programming). This information needs to be communicated again and again to parents and staff.

(15) What is the role of parents? What is expected of them, when, where and why?

(17) What medical information is needed from the physician? Is the handicapping condition identified and are the limitations considered and planned for? If not, how does one acquire the information?

(17) Prepare the instructors, aides and others who will be in daily contact with and responsible for the childen. They need to prepare themselves mentally so they can comfortably and matter of factly share information with children, parents and othe personnel.

(18) Evaluate the classroom. Careful consideration needs to be given to the spatial arrangements, the developmental levels of the children in the room, the cognitive levels, the materials needed to accomplish the goals of the children and the services to be delivered in the classroom. How does each consideration affect the normally developing and handicapped child in the room?

(19) Evaluation. How will all of the information be pulled together to account for changes occurring in children, in the program, with the parents and with regard to reporting to all of those agencies which might provide financial support? Design a simple plan that tells you each identified section of your program does or does not work. This will help to identify how to make changes.

STRATEGIES

Planning

A very important first step is the development of an overall plan with a timeline of events for two years. It should include all tasks to be to be achieved and the budget considerations necessary to accomplish the tasks. The overall plan should be available to staff, as it serves to remind staff in what direction the program is going and what evaluation strategies will be used to determine goals that have been accomplished. This project considers this not only important but essential to program staff who might not be the same persons year after year.

Next, the budget needs to include all planned sources of income and projected expenses. It is important to note that if a program is providing child care and any part is subsidized by parent fees, a minimum of 12 months is required before enrollment is stable enough to allow this budget category to stabilize. All other sources of revenue need to have been researched carefully enough to be reasonably secure as the program continues. Many other budgetary considerations are equally important, but this section is not focusing on the establishment of a child care program budget. These two issues were new to this program, so therefore they seem worthy of mentioning.

After the overall plan has been established, the next step is advertising the services to be provided. This project's first attempts at advertising were aimed toward public and private health care providers, agencies providing services for families, community mental health agencies, child care referral agencies, and all social service agencies throughout the city of Seattle.

Simple and inexpensive flyers were produced and sent to all the above mentioned resources. Notices appeared in newspaper classified sections. This included all of the local papers in the immediate area from which this program expected to draw upon working parents of normally developing children. Several months later, an inexpensive brochure was assembled with the help of a high school printing department. One year later 5,000 professionally developed pictorial brochures were printed; distribution of those brochures continues. The later date for production of this brochure was a good plan. As our program developed, the major features that we wanted included in the brochure became apparent. A brocure developed too early in the program could result in considerable waste of time and money. These brochures are a most useful tool for communicating the unique features of this program. Quality of the brochures is also important. The brochure of this project is a glossy three-fold item with pictures of unique program features. The intent was to communicate to the community the scope of the program and to highlight desireable features. The brochure still serves this purpose three years later.

Another product was developed to further explain the program. It is an item called "Program Information and Procedures." This "step chart", as it is called by the printers, continues to be distributed to professionals who have an interest in examining program components in detail. It has been useful in distributing to other early childhood practitioners, early intervention programs, potential funding sources, inservice presentors and agency personnel who are interested in focusing on the program components. It is a detailed expansion of the brochure which includes a description of the comprehensive services and program procedures.

The "step chart" is so named because each page overlaps another and flips up, so at a glance the reader can clearly

see the program component titles printed on the bottom of the page. It is approximately 8 1/2 by 11 inches. Positive comments are always remarked about this product from readers. It is worth the expense and saves many hours of answering questions. Though it becomes necessary to revise this product from time to time, it is the suggestion of this program that this product is well worth the time spent in designing and producing.

It is important to note that this document does not serve as a Parent Book. A parent book was designed and printed early on during program implementation so that parents have a document to which they might refer. More discussion about this item will be discussed in the Family Involvement chapter.

The suggestion to this point is that the previous strategies be carefully considered. While another program may not elect to address them exactly in this order, the experience of this program three years later is that the sequence of events as described is useful.

Staff Considerations

Next comes staff considerations. This program had an existing staff and began to create new staff positions after integration began. We recommend a complete staff training program be in place before new staff persons are hired. The information to be included in staff training will be discussed in the Staff Development chapter, but briefly, the training should include information about the decision-making process in the program by which all decisions will be made, strategies for integration activities in the classroom, parent counseling techniques, problem solving strategies for difficult issues, and time management techniques but to name a few. However, the objectives, as

outlined in this program's overall plan, had to be implemented with existing staff and new staff who were hired working closely together to become one newly expanded unit. Within one year, this project expanded from 10 staff persons to 21 and from 24 enrolled handicapped children to 48 enrolled handicapped and normally developing children.

The reasons for this were simply economics. The fiscal agency did not have the resources to close the existing program and wait for all children to be identified, staff to be chosen and trained and program to be implemented. This program could close for no more than a few days, so the task of smoothly integrating the program was not that smooth for quite a few months. The important point to consider is that with these constraints, the program still managed to accomplish its goals and remain on a reasonable time line while doing so. The commitment of the staff was an essential ingredient.

Implementation of Services

The program determined early that it would provide full day services in "developmentally integrated groups" of 8 children (see description in Services to Children chapter). The process by which this was accomplished is explained in the following description.

The month designated as program implementatation month (September, 1980) found 24 handicapped and eight normally developing children enrolled. The normally developing children were enrolled in response to advertisements and publicity. Intake had been completed and the "family unit" (as described in Services to Children chapter) was ready to become a reality. In the program that month, four family unit groups existed; two with the desired composition of four handicapped and four normally developing children and

two still containing only eight handicapped children.

Each group was, and still is, staffed by a team of educators, one a certificated special education teacher and one an early childhood education teacher. The therapists providing services to handicapped children do so within the classroom environment.

The following month four more normally developing children were enrolled and a new early-childhood educator was hired to team with the special educator. The same procdure was repeated until all six family units of eight children, were completely integrated with the desired composition.

This process was completed six months from the inception date. Given the constraints with which this program was working, a month was a reasonable time to screen children, complete the intake process and hire a new teacher. The project director was responsible for most of this process, while the Family Services Coordinator was working as a part of the multidisciplinary team and focusing not only on the home program for handicapped children, but also assessing the needs of the families being served in the project. Responsibilities change as the program develops.

Attention was focused as closely as possible on the developmental stages of the children referred to the program. The intake objective was to produce the desired balance of stages of development described in the chapter on Services to Children. Compromises were made so that the program could be integrated. The first priority was completing the family unit groupings with handicapped and normally developing children. This was important since this was the way the program had been described and there was a need for parents to feel comfortable with the program; it was important that it match in reality what was presented earlier only on paper. All of the parents of normally developing

children expected to pay a monthly tuition. Choosing from the normally developing children on the waiting list, the intake team always attempted to select those children whose developmental stage matched that age needed to complete the developmentally integrated grouping.

The monthly tuition paid by the normally developing children's parents assisted in providing the revenue source for the teacher hired for each group. This is important to note, because the program operated on a tight budget and hiring another teacher was dependent upon enrollment. This is a reality in implementing an integrated program and full day child care program.

By this point in time, the program had doubled in size. Appropriate educators now staff the developmentally integrated family units, all groupings are intact and the program is completely integrated in all aspects. The staff includes 12 teachers, early childhood educators and special educators, an occupational therapist, physical therapist, 2 speech pathologists, one full time family services person and one half time family services person, a cook, nurse and project director. The staff development chapter contains further information on staff roles and mechanisms for funding various staff positions.

This project considers the composition of the staff as ideal in terms of ratio and personnel to provide services to children. Implementing an integrated program is not dependent on availibility of all of these staff positions. This program's first consideration was adult/child ratio, then support services. Based upon state child care licensing guidelines and this project's conclusions, a ratio of 1 teacher to 4 children is preferred and maintained (further explanation in staff development chapter).

Comments and Suggestions on Strategies

Following are suggestions on the integrating strategies used by this program:

If at all possible, have funding secured for the initial six month period so the program does not have to be overly concerned with parent tuition or other funding sources until the program reaches the completion of the first phase. That phase will depend upon what each program designates it to be when designing it's plan of action. However, if this is not possible, it should not detere the development of an integrated program. Budget matters can be extremely anxiety producing. This can be a serious drain on energies needed for working with a new staff, considering new program ideas and managing all of components in implementing a new concept.

Another important consideration is the ordering of all equipment in an organized and systematic manner. Equipment purchases should be based upon what the program plans to accomplish with the children. This program embraces a cognitive-developmental approach. Because of this it was necessary to develop rules for selecting equipment. Each program must do this. This program considers, as equipment selection criteria , educational premise, developmental ages of the children, teaching objectives, therapy objectives, assessment procedures, cost, time and shared use. These are but a few to be considered as equipment is purchased.

Ask assistance from parents. Regard them as help-mates in their child's other home. It is our experience that parents will respond when they are asked to do something specific and reasonable.

With regard to staff development, it was not possible to close the program and acquaint all staff to the scope, goals and objectives of the project. This child-care program serves working parents; suspending services for a lengthy period of time was not an option. Although all staff were eventually trained to the procedures of the project, the strategy was to provide both verbal instructions and written material to new staff persons. Each person was a part of a team, so becoming acquainted with the scope of the project was made easier by having a person with whom to work closely (i.e. team teacher, team therapist).

Although there were guidelines for new staff, the learning process was still a "jump in" and learn process. Staff persons were expected to read the literature available on integrated and mainstreamed programs provided them and begin to identify needs. This is part of the staff development and evaluation plan that is discussed in that chapter.

Designing the child environment was an important consideration. Before the first family grouping was integrated, the necessary equipment was purchased for each room. Each room was designed to be a self contained family unit. Considerations were the characteristics of a 0-36 month of age population, the adaptive equipment in the room, therapy equipment and the educational principles to be implemented in the room. The appearance of the most normal and usual early childhood setting was the goal.

Parents were instrumental in restoring and painting rooms to be used as the family units. This occurred through Saturday work-parties for several months before the first family units were implemented. Initially, all of the participants were parents of children with handicapping conditions. They were so eager for their child to participate in a typical early childhood program that they made the commitment to prepare the environment so that it could happen.

EVALUATION

Integrating normally developing children into an existing specialized program or mainstreaming handicapped children into an existing early childhood program are two different plans, both difficult and in need of ways to evaluate the effectiveness of each.

As has been described, this program existed as a specialized early intervention program. Our first consideration was that this program did not want to have fewer normally developing children than handicapped children. The rationale was that there were old stereotypes to be overcome that might be difficult to overcome with fewer normally developing children. The fear was that parents might be hesitant to place their child in such a program. With no strong evidence in the literature supporting an appropriate ratio of normally developing to handicapped children, this program set out to dimenish old stereotypes by capitalizing on an urgent need for child care for normally developing infants and toddlers.

The building this program occupies accommodated the doubling of size to include 48 children. From the perspective of parents of normally developing children, the strongest points for the integrated program were the desire that their child experience other people who were different and the emphasis on individual program planning for each child. The high staff/child ratios were also a strong point for them. These continue to be strong points of consideration for parents, both of normally developing and handicapped children.

This program has been in existance for 3 years and one of the strongest arguments for integrated and mainstreamed

programming comes from satisfied parents throughout the community. Parents complete a final program evaluation before leaving the program. During the time their child is in the program, they have the option to evaluate services at the checkpoints (i.e. conferences, parent meetings, needs assessments).

The program staff evaluates the methods and strategies used for the integrated services by means of questionnaires administered annually, usually at the end of the program year. Questionaires from the past two years yield information that the staff has acquired a much larger scope of child development information for use in education and therapies. The staff reports that, both individually and collectively, they view the child more as a whole person with a handicapping condition being only one component of that person. They feel that this is a result of working with the integrated population. The staff reports that they are more aware that each child has particular characteristics for which one adapts the environment, whether normally developing or handicapped.

Each program will want to design its own evaluation format for the integrated or mainstreamed aspect of the program. It can be as detailed or simple as time, understanding of evaluation processes, and ability to design forms permits. Each program will want to have some measure of satisfaction for purposes of staff, parent and community information.

In this program, through the evaluation process, the parents report the benefits of integrated programming to include: the knowledge that they share similar child rearing problems with other parents; that they are not alone in the parenting process; that all parents must advocate for better services for their own child as well as others; and that they wish their child might be a more sensitive and/or accepted human being throughout life.

For the children the benefits are measureable through growth and development recorded through instruments that are designed to be as objective as possible, through the child change data generated from their individual development plans, through the changes as measured by informal and formal checklists, and documentation of interactive play behaviors. It is not possible to capture the subtle events that occur in the child's environment each day so it is difficult to systematically gather this some information. Daily, one can observe the benefits of children caring for one another emotionally and physically, even at these early stages of development, and encouraging, modeling and interacting with one another as if it is the most natural way of behaving. In this environment, the observer is always unhappy not to have the time to document such interactions in a more systematic manner.

During the evaluation process, this program reached the conclusion that the the equally matched number of handicapped and normally developing children is a reasonable ratio. This conclusion was reached through the following information: In this program, where the match was 24:24 of each, the absentee rate is always greater with the handicapped children. On any given day, more normally developing children are usually present than handicapped. If there were too few handicapped children, they could become the "novelty" in the program. This is a consideration for planning.

The ratio is desireable from the perspective of parents of normally developing children. Due to the equal match in each child's room, parents know their child is receiving an appropriate amount of attention and not just "being there" as a model. The parents of handicapped children express the assurance that their child is not lost in the shuffle of children who may be more capable or able to have their needs met by demanding them. This is particularly true of mul-

tiply handicapped children. The parents report satisfaction with the match.

The staff members express satisfaction with the equal match. In the evaluation questionnaire, they express a dissatisfaction with having more handicapped children in a developmentally integrated group. They feel that this would decrease the amount of time spent working individually with each child. They also express strong concerns about any increase in group size with a group of children under 3 years. Individual attention decreases with the inclusion of another child to a group. This opinion has budgetary considerations that have to be considered by the program administrator. In this program, the staff members and program administrator always work with the constraints of staff, child, parents and budget in mind.

Evaluation Summary

This program continues to have problems and unresolved issues as would be expected of any program struggling with a concept that is not thoroughly researched and practiced. As new literature is examined and elements of studies are replicated in other projects, this program hopes to improve not only the quality of services, but streamline its procedures, practices, evaluation systems, and delivery of services. The vision of improving the quality of life for children cared for outside of the home, through an integrated setting and an individualized approach for each one, remains a commitment of this program. Without the goals, the commitment and the vision this program would still be comfortable serving 24 handicapped children, year after year. Twenty-four other normally developing children might never have experienced being accepted because of one's differences, not in spite of them. Forty-eight families might not experience their many likenesses with other families in

their community. Perhaps only the differences would be seen.

BUDGET CONSIDERATIONS

The increase in costs associated with doubling the size of the program were covered by the following sources: parent fees for normally developing children accounting for approximately 20% of the overall budget; the initial federal grant covered 20%; The State Division of Developmental Disabilities covered approximately 20%; Title 1 monies added approximately 25%; contributions and other agency funds added another 10%. The increase in costs were associated primarily with the six new early childhood teachers. The parent tuition from 24 normally developing children at $300 per child covered the increased costs associated with appropriate staff coverage for the newly created family unit groupings of 8 children.

The federal grant was instrumental in assisting this program by providing the costs associated with several positions (two therapists, a portion of the nurse's salary, and a portion of the Family Services Specialist salary). The initial grant assisted in providing materials associated with the goals the program was to accomplish.

The message to be conveyed here is that there were no special costs for integrating this program. The increase in program size created by the addition of 24 normally developing children, brought costs, but they were covered by the tuition paid by parents. Other positions provided by the grant were in addition to the services provided in the original program serving only handicapped children. The grant provided money for positions to explore new methods and strategies for providing education, therapy and support services to handicapped children. An integrated program is a way of providing better services because the services occur in a more naturalistic setting but there were no extra costs because of the integrated model itself. This program

expects to support those positions from additional revenue sources upon termination of the federal grant.

It is important for the reader to understand that the integrated program did not create costs that would not have been incurred if the program had doubled in size and included only handicapped children. In fact just the opposite occurred. In this program, the parent tuition for the normally developing children amounted to more than the funding would have been for including 24 additional handicapped children. The current funding source for handicapped children does not provide a differential reimbursement rate for full day services in this county. Therefore, the parent tuition is more reflective of the actual costs for full day services. Again, it is important for the reader to remember that a value judgment was made that this program could provide more appropriate services in an integrated setting. That did not give this program the option of expanding to include 24 more handicapped children.

The writer's suggestion to a program considering an integrated program is to consider its program goals, the services it wishes to provide, how those services will be provided (direct, contracted for, part time) and to explore the possible revenue sources to provide those services. It is essential that the program administrator be well versed in the availability of revenue sources and skilled in making appropriate use of them.

This program recommends a diversified funding base for operation. Though the management problems increase, the sudden loss of a single revenue is not devastating to the entire program. The increase of management problems is due to the different guidelines and expectations of each source of revenue, the different times each proposal is due, the reporting systems required by each and the continual process of meshing them all together. The alternative is to depend

on one source that may not be a consistent source of revenue.

METHODS SUMMARY

(1) Optimally the whole staff should be well read and knowledgeable in the concepts of integrated and mainstreamed programming. Minimally, one person must know the literature very well and be committed to providing a method for others to come to know the expanding body of information.

(2) A clear commitment of the staff to the concept of mainstreaming.

(3) Establish an overall program plan projected on a two year timeline.

(4) Develop an evaluation plan that includes a strategy for evaluating each component. Determine how each relates to the overall evaluation design. Build in checkpoints. An evaluation plan is ESSENTIAL.

(5) Define the services to be provided. Define the staff and parent roles and expectations. Establish a plan that troubleshoots and anticipates problems staff and parents will encounter. KEEP TALKING AND LISTENING.

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Chapter IV

THERAPIES IN AN INTEGRATED OR MAINSTREAMED EARLY CHILDHOOD PROGRAM

Speech, Language and Communication Therapies

RATIONALE

The premise of this chapter is that the reader understands the role of the speech and language clinician in the intervention process for young handicapped children. From the perspective of this program, that role is to provide therapy to children who have been identified as having a delay in the area of communication. The purpose for doing this is to help develop the ability to use a conventional symbolic system; to develop an appropriate language environment and stimulate the development of concepts for language production. There is clearly a need for attention to the speech and language areas with handicapped children this young. The child with a delay in the area of communication is the target child.

METHODS OF INTERVENTION

The first method of intervention includes direct child contact. This includes feeding, individual therapy in the classroom or clinic room. Small groups for children with similar language goals are usually treated outside the classroom. Children with perceptual-motor related language problems are treated in small groups by the Communication

Disorders Specialist (CDS) and the Occupational Therapist (OT) as are children with sensory integration problems. Small group language activities facilitated by the CDS and teacher occur in the child's classroom.

Informal stimulation for communication development occurs during peer group activities when children are with others at the same level of cognitive development. This includes normal children, who are present in the classroom during feeding, dressing, toileting and other routine activities.

Another method of intervention involves parents. Parents are involved through direct conferencing, phone, notebook entries, written progress reports, demonstration of treatment strategies and the resolution of specific problems.

A third method of intervention depends heavily on staff. Regularly scheduled staffings focus on pupil progress, treatment strategies, and problem solving. These serve as checkpoints for coordinating all services to individual children. Informal discussion occurs on a daily basis and especially after co-therapy sessions with the occupational therapiest, physical therapist (PT) or teacher. A multidisciplinary approach is the preferred arrangement.

STRATEGIES

The initial evaluation of each child provides information on receptive and expressive communication, including articulation, and on cognitive level, particularly as it relates to prerequisites for language and further language complexity. Play development, oral-motor development, feeding skills and hearing sensitivities are a usual part of the initial evaluation.

Speech, language and communication evaluation include (a) informal observation during classroom play activities, (b) information obtained through parent interviews, (c) administration of formal and standardized tests, and (d) completion of the developmental checklists used by teachers to elicit specific behaviors. A description of the assessment instruments commonly used in this program is as follows:

Formal speech/language materials with probes are typical used for communication assessment. These sets of materials and stimuli are used to elicit non-verbal language prerequisites, semantic relations, comprehension and expression. Developmental norms used to analyze the informal data were developed by Miller and Chapman (Miller, 1981), Carpenter and Coggins (1978), Kreigssman (unpublished), Tyack and Gottsleben (1974), Bloom and Lahey (1978), Walmsley (1982) and Bang (1975). Formal and standardized speech and language instruments include the Sequenced Inventory of Communication Development (SICD, 1975) which is used with all children except those functioning below approximately 8 months. The Receptive and Expressive Emergent Language Scales (REEL) is used primarily with children functioning under twelve months of age. The Peabody Picture Vocabulary Test (PPVT, 1965) is used with children who are cognitively at or above twenty-four months of age.

The Expressive One Word Picture Vocabulary Test (Gardner, 1979) is used with some children cognitively above two years of age. It provides a score for expressive single word vocabulary elicited from pictures. It is a quick and easily administered test that can be used to supplement information obtained from other language tests. It provides age norms as low as two years as well as percentile ranks and stanines for deviation IQ.

The Vocabulary Comprehension Scale is used with some children functioning at or above two years. The Non-Verbal Indicators of Communicative Exchange (NICE) and the Gestural Approach to Thought and Expression (GATE, 1977) are used primarily with very low functioning children.

The Photo Articulation Test (Pendergast, 1969) in its adapted form is used with some children functioning at or above two years who have a suspected articulation problem. Informal speech samples obtained during play situations and analyzed for presence or absence of developmental speech sounds complete this section of the protocol.

COGNITIVE ASSESSMENT

Informal sensori-motor scales adapted from Branston, Miller, Wanska, Raichle and Eng (1977) and Uzgiris and Hunt (1978) are used to assess all children, to compare cognitive and language development, and to determine appropriate peer group placement. These scales yield information on cognitive development in five areas including object permanence, means to end, spatial relations, causality and imitation (vocal and motor). Acquisition of skills in these areas has been found to be prerequisite to the development of language. Approximate age norms are provided (one through 24 months).

The Bayley Scales of Infant Development (mental scale) is used with all children for comparison of language results and to document changes that occur while in the program. This well standardized instrument was designed for children from birth to 36 months to assess sensory perceptual acuities and discriminations. The Bayley Scales also provide early indications of object constancy and memory, problem solving ability and vocalizations. The scales also provide data on verbal communication and the ability to form generalizations and classifications; important to abstract thinking. Results are expressed as a standard score, the Mental Development Index. Age equivalent scores can be determined from the published norms.

The McCarthy Scale of Children's Abilities is used to assess children functioning above the limits of the Bayley. It is a well standardized (N=1032) instrument designed for early identification of children with potential learning disorders and is intended for children 2 1/2 through 8 1/2 years of age. The McCarthy consists of 18 short tests of mental and motor ability, with results grouped in various ways to form six scales. These scales include verbal, perceptual-perfor-

mance, quantitative, memory and motor. The verbal, performance-perceptual, and quantitative scales are used to obtain a General Cognitive Index (GCI). Scaled scores and standard deviations are also listed.

The play component of the evaluation protocol is assessed with the Lezine (Lezine) scale and used with some children functioning birth to 24 months. During the assessment, children are encouraged to play with a set of toys which represent objects used in daily routines. Strategies of play are recorded and described by stage of developmental sequence. The Symbolic Play Test by Lowe and Costello (1979) is used with some children functioning one to 3 years. This instrument assesses early concept formation and symbolization, which precedes and develops in conjunction with receptive and expressive verbal language. Miniature toys which represent everyday objects are used to elicit play. This system, when used in conjunction with other tests, helps in differentiating children who have developed sufficient concepts and symbols from those who have not. Age equivalent scores are available.

The Miller Assessment for Preschoolers (MAP) is used for children with suspected sensory integration problems or signs of early learning disabilities. It has been standardized on children from two years, nine months to five years, eight months with items constructed around developmental variables claimed to be predictive of future school performance.

PROGRAMMING FOR CHILDREN WITH IDENTIFIED NEEDS

The following is a description of what occurs as a result of the assessments described above. In the initial staffing by the multidisciplinary team, the results of all administered tests are synthesized so the information is concise and useful. The CDS recommends goals in the areas of communication, cognition and feeding. The CDS is responsible for writing sequential teaching programs using normative data on developmental sequences and ideas adapted from commercially prepared programs as guidelines. The Communication Training Program and Dunst's Infant Learning are examples of commercially prepared materials that are useful. The CDS offers suggestions in the other areas of child's program, including behavior management and parent involvement to facilitate the child's learning objectives.

During the IEP conference that follows the assessment procedures, the CDS, along with the other members of the multidisciplinary team, interprets the assessment results for parents. Parental concerns are addressed and the goals are finalized. The goals are a part of the whole Individual Educational Plan for the child. The plan is projected on a 10 month time line.

Next comes the scheduling of therapy sessions and determining the type of intervention to accomplish the goals. This includes feeding and communication training in individual and small group sessions, during structured and unstructured times. The frequency of the intervention is established with the following criteria used as general guidelines:

(1) If language is a primary area of delay, children receive individual therapy 3 to 5 times weekly in 15 minute sessions.

(2) Individual therapy occurs twice weekly if language is one of several areas of delay.

(3) Individual therapy occurs once weekly if intentional communication is established with nonspecific gestures used as a major mode of communication.

(4) No structured communication therapy occurs if abilities at or near age level are apparent or if cognitive development is below the 8-12 month level.

(5) Feeding intervention occurs once or twice weekly if oral/motor problems are presented.

(6) Informal language stimulation occurs if children are seen for feeding, in peergroups, or in classroom family unit grouping.

Session length varies with individual children. The clinician will tell the reader that many well planned sessions has been interrupted by a cranky child, only to have the appropriate moments recaptured during an unscheduled diaper changing episode.

Peer Groups

Peer group placement, for all children, according to designated cognitive criteria, is the responsibility of the CDS. Cognitive criteria, based on Piaget's stages of sensorimotor and preoperational functioning, have been the basis for establishing the cognitive criteria. For example, the infant peer group includes children cognitively 1-8 months; the next group is cognitively 9-15 months; the next group 16-21 months; and the next group cognitively above 24 months. The CDS plans with teachers, from a cognitively

oriented curriculum, those key experiences to be introduced to the children in that group. This approach is consistent with this project's cognitive-developmental approach. These groups continue to be useful in yielding information about how children interact and respond to materials in different situations. Observations are made about how children behave in these groups and in comparison to their behaviors in their developmentally integrated family unit groups.

The re-evaluation process for each child occurs 5 months after implementation of the IEP. Each child is re-evaluated with the same instruments as were used in the initial assessment process. The information is synthesized into a written report. A conference with the other members of the multidisciplinary team and the parents occurs for purposes of discussion of the child changes and to discuss the future goals. After the conference, the written reports are forwarded to appropriate persons (i.e. parent, physician). Parents are an integral part of the intervention strategies at whatever level they are comfortable. Emphasis is placed on the parent's enjoyment of their child and then facilitating communication skills through play. The CDS's role is valuable for the parents when it is time for the child to exit the program. At this time, the CDS can assist the parent in becoming acquainted with the available options for programs when the child leaves this program. As a part of the multidisciplinary team, the CDS assists in determining a suitable placement for the child.

So far, the narrative has focused on the handicapped child in the integrated program. The CDS' role includes initial assessment of normally developing children as well for purposes of peer group placement. The Bayley scales and the cognitive scales are used to determine the placement, just as they are with the handicapped child. These assessments provide useful information for the CDS when looking at the normal acquisition of skills in children and determining

what is an appropriate direction with children who are exhibiting delays in the areas of communication.

The Use of Hearing Screenings as a Component of Programming

Hearing screenings are conducted through play audiometry for all children who are able to learn the procedure. Visual Reinforcement Audiometry is used for children who cannot learn the play procedure. These screenings occur at least once a year. Priority for assessment is given to children with suspected hearing loss, history of middle ear problems and no previous testing records. Referrals for medical evaluation, further audiometric evaluation and other medical concerns are a part of the CDS' responsibilities. These assessments are conducted with all children in the program.

These screenings are a valuable addition to the communication portion of the program because they apprise parents of normal stages of communication,development, suspected problems and appropriate parent strategies. They provide parents with information and knowledge not commonly available in most child care programs. Many programs do not usually employ a CDS and often times do not have adequate resources available to them. In addition, the CDS provides the staff with invaluable information on a daily basis, thereby facilitating the acquisition of the child's individual communication goals within the developmentally integrated family unit groups.

The Role of The CDS in a Full Day Program

During the second year of the demonstration project, the CDS composed an outline of assets and liabilities regarding the role of the CDS in the full day child care program. A description follows:

The influence of a full day model on therapy strategies makes it possible to include individual and group treatment sessions at the most optimal times for the child during the day. Skills are initially learned in both individual and group situations, so generalization to group settings does not require further programming as an additional learning step. Various activities during the day present different opportunities for the child to practice the skills which the clinician may be monitoring.

In a full day program, time flexibility allows for cooperative efforts among all therapists. The full day setting encourages the whole child approach because therapists incorporate goals from other developmental areas into their strategies. Problem solving can occur through a more systematic team approach.

The advantages of treatment within a naturalistic setting make the therapy more relevant. Needs are identified and treated in the settings where the child is using the skills. Generalization occurs from the child's therapy session to the other parts of the child's environment. Skills are acquired simultaneously in the therapy session and the daily routine. The number of opportunities for intervention are great when therapists are involved in play, feeding, naptime, arrival, departure, diapering and the transitions between these activities.

The influence of observing normal development has had a significant impact on intervention strategies with children who have special needs. Therapy activities have become more child centered, with therapists adapting their plans to the immediate interests of the child. Unnatural learning tasks have been reduced (i.e. use of imitation and nonmeaningful reinforcers) and the focus is on facilitating therapy goals through spontaneous play.

EVALUATION

Strategies used by this program to evaluate the effectiveness of the communication component have been specific to overall program goals, communication goals and individual child goals. For example, this project designed an overall program evaluation design, of which the communication therapy component was a part. The evaluation criteria includes child change over prescribed periods of time, comparison of strategies, use of therapists time and parent response to the therapy component. The therapist uses a data-based record keeping system to document child change over time.

The child's individual communication goals are stated in behavioral terms, written in the IEP and assigned specific criteria to help determine when the goals have been achieved. The therapist monitors these criteria during individual and group sessions. These data are recorded on the IEP, so the entire team is aware when objectives have been met. The therapist uses baseline data and initial assessment data as a basis for pre-treatment status. The re-evaluation data provides the information about the effectiveness of the intervention strategies. This re-evaluation occurs 5 months after the intervention plan is in effect and again at the end of the 10 month IEP. The assessment protocol for each child, administered every 5 to 6 months, records the changes that have occurred during the time the interventions are in process. If the individual child remains in the program for more than one year, then the IEP for each year can be compared, one to another. No child is compared to another child. Each child's performance is based upon baseline and pretreatment information, the interventions that occur and the data that result from monitoring the interventions. The assessment instruments measure the changes in the child's performance over a period of every 5 to 6 months and across a 10 month timeline.

This program continues to employ two speech/communication therapists. Each is responsible for an individual caseload of 14 to 16 children identified as needing specific communication therapy. Each is responsible for the program documentation as it relates to the normally developing children's progress within the integrated program.

This program has been fortunate to have the resources necessary to hire two therapists. If a program cannot afford two, or even one CDS, the program manager must be responsible for securing the needed services in some other way for a child with communications delays.

BUDGET CONSIDERATIONS

The positions in this demonstration project have been paid for by separate sources. One has been funded by the federal grant and the other by federal funds from an entitlement act that makes such monies available to institutions serving children with special needs. In the opinion of the writer, it is the responsibility of the program manager to know the funding sources available to provide the needed services to the population of children being served. The suggestions are to identify the therapy need and search for the source to fund the position. Size of the population being served is another consideration for obtaining the services elsewhere or creating a position within the program. Again, for the scope of this project during the demonstration phase, the caseload of each therapist has consistently been between 14 and 16 children. Given the responsibilities of the full day setting and the demonstration questions to be answered, this has been a usual caseload for a practicing clinician. This seems a usual size caseload for many therapists practicing in this urban area, though size or program, age of child and budget considerations often determine availability of services and size of caseload.

If a generic program chooses to serve children with communication delays and cannot afford a therapist position, arrangements could be made for those services to be delivered through other sources. In this state, if the child were registered with the state Division of Developmental Disabilities, therapy costs could be included in the monies reimbursed to the generic setting. The communication therapies could be purchased from another source for those children. There are other options for securing services if a program chooses to serve a child with communication delays. Knowledge of revenue sources is a major responsibility of the program director.

METHODS SUMMARY

(1) The use of the multidisciplinary approach in focusing on the needs of the child with communication deficits.

(2) Focusing on the strengths of the child and building upon those strengths in all areas of the child's development.

(3) Parent involvement in all phases of the intervention process at whatever level the parent is able to facilitate the interaction.

(4) The establishment of clearly defined evaluation and programming procedures that all staff and parents understand.

(5) The evaluation of the program component as it relates to other components of the entire program. All program components need to fit into the overall evaluation design.

Occupational and Physical Therapies in the Integrated or Mainstreamed Program

RATIONALE

The premise is that the reader understands the respective roles of an occupational and physical therapist. In this program, those roles include providing therapy for children with a disability affecting their physical development; normalizing muscle tone; improving muscle tone; improving balance and equilibrium reactions which will facilitate normal, active movement; and development of feeding skills which will lead to the child's optimum level of independence. In this infant and toddler program, the two therapists, who have an emphasis on pediatrics in their background training, provide these services for neurologically impaired children and any child exhibiting fine or gross motor delays in their development. The therapies to this population are for the purpose of facilitation of more normal movement patterns in the child with atypically developing motor patterns.

METHODS OF SERVICE

The philosophy of therapy in this program is based on neurodevelopmental and sensory integration (Ayres) treatment approaches. The physical and occupational therapists (OT/PT) divide the caseload so that each has a balance of presenting conditions, severity of conditions, chronological age and family concerns. Both consult with one another and share strategies and treatment sessions on each caseload. They schedule regular inservice times to review treatment strategies, include parents in evaluation and treatment sessions, whenever the parent desires such inclusion. They

consult regularly with staff. They provide therapy through direct child contact, both individually and in small group sessions. Included in methods is the assessment of children on the home based program and recommendations given to the Family Services Coordinator for their therapy need, or referrals to other treatment facilities.

Also included in methods is small group treatment, informal facilitation of individual child goals in classroom setting and the observation of normal growth and development of the normally developing children. This observation is for the purpose of more precise evaluation of the atypically developing motor patterns occurring in children with specific handicapping conditions.

STRATEGIES FOR INTERVENTION

Assessment and Planning

Upon entry into the program, each child with a handicapping condition is evaluated by one of the therapists as a part of the multidisciplinary team approach. Joint assessments with teachers and communication therapists and sometimes parents have become routine for initial assessments. A variety of assessments are used as indicated, including the Peabody Developmental Motor Scales, Movement Assessment of Infants, Miller Assessment Of Preschoolers and The Bayley Scales of Infant Development. Observation of tone, postural responses, reflex integration and quality of volitional movement are observed specifically by the OT/PT team.

A sensorimotor feeding evuluation is also performed in conjunction with the communication therapists. These assessments occur as a part of the initial assessment protocol and in conjunction with other similar assessments. Often they occur simultaneously with other assessments. All assessments are completed within 30 program days upon entry into the program.

After the child's assessments have been completed, the child's individual treatment needs are determined. Goals are determined in the areas of gross, fine motor, feeding and self help. A treatment plan consistent with the child's other goals is then devised. The treatment plan takes into consideration all other skill areas where goals for the child have been identified. Again, as in every intervention strategy, the effort is to coordinate with other team members who will be responsible for the child. The goals, objectives, and strategies are all congruent and compatible and as non-intrusive as possible on the child.

The team communicates with parents in the initial and succeeding conferences. Included in the child's treatment plan might be individual sessions with the PT/OT at regularly scheduled intervals, small group sessions if appropriate, and time within the classroom for feeding and consultation with teachers. Home visitations are planned in some instances to allow teaching and follow up of therapy objectives. Parents are included wherever their interest level, emotional adjustment and circumstances allow them to participate. This varies with each family and is very individual. The attempt is always to encourage and assist, as it is recognized that the parent is the most common care-provider and ultimately the responsible person for that child's development.

Following the initial assessment, a report of the assessment information and subsequent treatment plan is written and sent to parents, the referring physician and other health care persons or social service agencies involved with the family. This is done for the purpose of establishing rapport with all persons who will be regularly interacting with that child. A real attempt is made to keep information flowing in all directions.

Regular therapy progress data are collected on each child's treatment plan and re-evaluation occurs every 5 to 6 months. All written reports following evaluations are communicated to appropriate persons and agencies.

Programming for Children with Identified Needs

The OT/PT meet twice weekly with the other members of the multidisciplinary team. The OT/PT are included in several teams. For example, each teaching team responsible for a group of 8 children is a part of a multidisciplinary team providing services for that group. So the OT/PT become

members of each team. They meet with each team every 3 weeks for purposes of discussions regarding pertinent issues, treatment plans, problem solving, child progress and family concerns. Informal meeting times also occur as needed but this formal time is always scheduled. The team has found it helpful to prepare a simple agenda for the hour meeting and to attend to that agenda. It might be noted that in this program there is a value placed on good time management skills so it is common for any staff person to comment that the agenda is not being attended to and return to targeted concerns.

Small group therapy sessions with the Communications Disorder Specialist (CDS) which are oriented toward sensory integration and language stimulation occur with children for whom that strategy would be appropriate.

Another strategy is the OT/PT participation in assessment of all children using the Bayley for purposes of documenting child change while in the integrated setting and for placement in the cognitive peer groups. The OT/PT, as a team, work and plan with teachers in the lower cognitive level peer group. While they are a part of this group, they can attend to individual therapy needs of the child who is a part of the group. Often times, this includes children who are more severely involved and receiving more therapy. They can also model appropriate handling and positioning strategies for the educators who are a part of the group.

Other strategies include coordinating therapy of children with neurological diagnosis. These children may be receiving additional therapy services through outpatient departments at other centers. The therapists meet with other departments and agencies as is needed.

Therapists consult with other staff members regarding special adaptive equipment for home and classroom. Therapists

in this program also focus on inhibitory casting as a treatment strategy and, when appropriate, for a specific child. Each has received the appropriate training in the techniques.

The reader can see the flexibility needed by therapists working with this young population in a full day setting. For example, during naptime, the OT/PT team will take a turn in the naproom to consider the sleeping positions of children with atypical motor patterns. They are often involved in diapering, so as to model the most effective style to facilitate a particular therapy goal. With the therapists involved in every aspect of the child's routine each day, they can respond to many episodes of questioning and concern from educators and parents. They are also more accessible to the arriving and departing parent.

Children involved in the home based program are evaluated by the therapists and recommendations are made for outside service providers as needed. The therapists do not typically provide services to this group. Needed therapy can usually be arranged through and provided by outside sources. The Family Services Coordinator maintains contact with home based children. Through frequent meetings with the Family Service Coordinator, the therapists have a beginning rapport established with a child likely to move into the center.

Included in the therapist's responsibilities is the supervision of students who are placed in the center through local schools and colleges of physical and occupational therapy training programs. Once monthly, the therapists present a topic to the staff during staff training, primarily focusing on aspects of sensori-motor development and handling aspects that are especially useful in the classroom. Occasionally, they will be asked to speak during the evening parent meeting. Usually they plan one annual formal evening presentation. Upon occasion, therapists will conduct special

workshops for the purpose of sharing more information about the facilitation of more normal movement patterns, adaptive equipment, and a variety of other topics that are of interest to staff, parents and other professionals in the community. These activities are undertaken as needed, as interest indicates and as time permits within their busy schedules.

Role of the OT or PT in a Full Day Program

During the second year, given the constraints and allowances of a full day child care program, the therapists reached some conclusions that provide a framework for consideration. These are presented as follows:

When asked the question "how has the full day model influenced individual therapy time?", the answer is that traditional therapy sessions usually last one hour and during that hour therapy has to occur, no matter what, because that may be the only time the therapist sees that child until the following week. In the program, due to naps, meal times and other activities, therapy sessions may last only 30 to 45 minutes. This may be more desireable, as it relates to the attention span of a particular child. More time can occur either formally or informally during other times of the day. This is beneficial to the child, but often is frustrating to the therapist who has a constantly fluctuating schedule. However, due to the length of the day, there is more flexibility in this setting than others. No matter which perspective one takes, there are, for therapists, benefits and constraints to working in the full day setting.

Since most parents involved in the incenter program are working parents, they seldom can be involved in regular therapy session. This can be compensated for with planned home visits, phone contacts, conferences, routine written

comments on therapy sessions in the notebooks and any other strategy one can dream up to include those parents who wish to be included. Again, this program has adopted the position that all parents wish to be involved with their child's therapy plan at some level.

In this program, small groups are more an option due to the availability of both children and staff throughout the day. Also, normally developing peers can be an asset to the small group settings, as they are curious as to where their friends are going in therapy. During this time, the therapists can make use of the events because appropriate modeling is often stimulated by the small group environment.

Due to the flexible schedule, there is increased opportunity for informal consultation time with all staff. Team assessments and therapy sessions have proven to be a valuable learning experience.

Again, feeding, diapering, handling, positioning and play interactions occur all day in this more natural setting. Opportunity to become involved in making these functions as therapeutic as possible is through increased opportunity to observe and intervene in self care, motor and play skills as they naturally occur. There is increased opportunity to manipulate the environment to suit therapeutic goals while not manipulating the child. Ongoing problem solving occurs throughout the day. Monitoring of program goals and intervention strategies occurs more frequently as the child's patterns are observed in a more naturalistic environment throughout the day.

The influence of normally developing children on therapy has given the therapists a terrific opportunity to observe patterns of normal development and to develop an appreciation of the wide range of skills included in any stage of development. There is an increased appreciation of what is

needed to provide the most effective therapy.

EVALUATION

Strategies used by this program to evaluate the effectiveness of the occupational and physical therapy component have been specific to overall program goals, therapy goals and individual child goals. The evaluation criteria include child change over a prescribed period of 10 months, comparison of strategies, use of therapists time and parent response to therapy component. The therapists use a data-based system of recording child change. Also included are anecdotal records in narrative form for individual progress notes. These link to the behaviorally stated goals on the child's IEP, where specific criteria are assigned to the behavioral statements. This evaluation component is identical to the description in the evaluation section of the communications therapy chapter. Refer to that section for detail.

Again, to be stressed in this section as in others, is the cooperative efforts that reduce redundency of effort in all areas. The suggestion of this program is that in the overall evaluation design of a full day child care program that includes a therapy component, the component be carefully woven into the plan so it doesn't become a separate component functioning independently of the other activities of the child's day. This needs to be given careful consideration, as it can happen. This is often the case in hospital settings and in public school settings. Therapies occur independent of whatever happens with the individual child. This program attempts to address these issues through re-evaluation of time spent in classrooms, duration of sessions, who is included in the sessions, and a variety of elements that serve to make therapies an integral part of the naturalistic early childhood environment.

BUDGET CONSIDERATIONS

Again, the positions of occupational and physical therapists in this program are funded through a variety of sources. One position is funded by the federal grant and one position is funded by yet another entitlement act that makes such monies available to institutions serving children with special needs. As was stated before, in the opinion of this author it is the responsibility of the program manager to know the funding sources available that will provide the needed therapies. In other words, because one avenue of funding is closed, do not rule out the possibility of providing this service. Search for another source to fund the necessary position.

For example, this project has not the resources to employ a therapist for the home based component. However, as is described in the Home Base Chapter, the Family Services Coordinator secures consultation from incenter therapists, direct services from outside sources and they are all coordinated by the Family Services person. Consideration needs always to be given to the cost effectiveness of any position in its relation to the service needed. The suggestion is to determine the therapy needs then problem solve as to the most cost efficient strategy to acquire these services, while most effectively meeting the therapy needs of the child.

METHODS SUMMARY

(1) The use of multidisciplinary approach in focusing on the needs of the child with atypical motor patterns.

(2) A concerted effort to focus on the strengths of the child and to program from that point.

(3) Parent involvement in all assessment and treatment strategies at the level desired by the parent.

(4) The establishment of clearly defined assessment, evaluation and programming procedures in the therapy component. This includes any procedures needed for coordination with other organizations and agencies who are providing services to the child.

(5) The evaluation of the therapy component as it relates to the overall program design, child change over periods of time, appropriate service delivery strategies and evaluation by the parents of children receiving services.

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Chapter V

NURSING SERVICES IN THE INTEGRATED OR MAINSTREAMED EARLY CHILDHOOD PROGRAM

RATIONALE

The need for a nurse in an integrated program is perhaps stronger than it might be for an early childhood program serving only normally developing children. The reason for this is that, in this program, a wide range of handicapping conditions is presented and the nurse is responsible for monitoring the resulting medically related concerns. Although a nurse is desirable in any program serving children under three years, this is not always possible due to budget constraints of most programs. This program employs a full time nurse who monitors the health status of both adults and children in the Northwest Center agency. The larger portion of her time is focused on the children with handicapping conditions. During the last three years the amount of time and use of time for meeting the needs of handicapped children in a full day setting have been explored and conclusions reached.

METHODS OF SERVICE

Methods for including the nurse in the integrated setting are through direct child contact. This is often in the form of daily interaction with each child and parent, or other caregivers who bring the child into the center. Direct child contact includes daily health monitoring consistent with routine procedures established by the center. Other activities include in-center health procedures, establishing emergency procedures, designing and implementing regular health screenings and monitoring those screenings. The nurse is also a link between the primary health care provider (usually a physician) and the parents; both of whom come into frequent contact with the center.

Another method involves keeping current with the individual medical history of each child, through requesting physical therapy prescriptions, monitoring and administering medications, and acting as a medical advocate for the health needs and concerns of each child. Although the more intense needs are usually exhibited by children with handicapping condition, the nurse monitors all children in this program in a similar manner.

Another service provided is monitoring of student nurses from the local universities and colleges throughout the school year. The program provides a community based setting for those nurses going into community health.

Another major task is that of providing resources, referrals, and other pertinent information to parents in the center. This is often a high priority for parents who have much medical involvement in their family life.

STRATEGIES

Assessment and Planning

After the intake process has been completed for both normally developing and handicapped children, the child enters the center based program. The nurse uses the information on the developmental interview to gain health information that might be relevant to the child's needs while in the program. Immediately upon reviewing the health information, the nurse submits a request for current medical information to the primary physician. This is a standard procedure in this program because judgments about any intervention process are dependent upon health needs having been met and adaptations made.

If the medical information has not arrived within two weeks, the nurse contacts the physician with a reminder that our regulations require current medical status for any child enrolled in this program. Children who have handicapping conditions often have a multitude of medically related personnel and agencies involved, or they may not have enough. Either way, coordinating the material for purposes of strengthening the child's individual program and keeping medical information current is usually a major task undertaken by the nurse. Children who are normally developing usually have one pediatrician or family practitioner so information is more readily available and arrives at the center in a more timely manner.

After receiving the requested information, the nurse, who is also a part of the multidisciplinary team, is the person responsible for arranging for or requesting any further assessments as they relate to health concerns. These practices are always coordinated with the parent, as well as other members of the multidisciplinary team.

During the time the nurse is waiting for the medical information to arrive, she is responsible for establishing routine screenings to include immunization monitoring, vision testing, hearing screening, nutrition screening and dental assessment. These are established on a schedule and information is conveyed to parents. These screenings are also mentioned on the child's individual educational program so they are in written form. Of special interest is the continual monitoring of middle ear infections that plague many children under the age of three years. A donation of an otoscope to the nurse from a group of parents now enables the nurse to routinely check children's ears. Often times teachers and parents will request such a check. These checks often result in referrals to physicians as well as eliminating referrals for complaints of ear infection that did not exist.

After the medical information is received, the physician contact established and all other procedures that have been described have been completed, the nurse participates in the multidisciplinary team assessment. This information is included in the assessment process and incorporated, as appropriate, into the individual education plan. The information about any restrictions due to medications, allergies, special considerations and admonitions that appear relevant is useful here. All of these procedures generally occur within a 4 to 6 week period, so that all has coincided and the child's program plan is implemented within 30 program days after entry into the in-center program.

The nurse continues to monitor each child's health needs and regularly gives input into the written documentation that goes to each child's physician and parent. Often times, a child will have many other agencies involved because of the nature of the handicapping condition or funding source so the nurse is responsible for coordinating all written infor-

mation and submitting it to the involved agencies.

As is consistent with all other evaluation procedures, five months after the child enters the program the nurse participates in the re-evaluation process by offering current collaborative health information.

Other strategies include the daily contact with parents and with those who come into the center. Each morning, the nurse makes rounds in the family unit groups to check the general health of each child. At that time she establishes the daily schedule of a child who will need medication, sees that the proper procedures have been observed for administration and makes any clinical notes that are necessary. It can be noted here that this program is in an urban area where there are no other full-day programs for handicapped children so they come from all over the city. The range of cultural backgrounds, socioeconomic status, environmental status and other variables are as many as are the handicapping conditions. Often the nurse must be the liaison with other agencies, e.g. Child Protective Services or Child Welfare, for purposes of communicating information. Her clinical notes on a daily basis become important information as well as a useful teaching tool for many families.

Screenings

The strategies surrounding screenings include arranging for them from a variety of sources. Vision screening is arranged for annually with a pediatric opthalmologist who works in the Seattle area. This contact was made by the nurse and the program director and has been working successfully for 3 years. We approached this person with a need and he has cooperated with this program. This opthalmologist makes recommendations based upon his findings. The nurse is responsible for communicating the results of the

findings in writing to the parents. She arranges for referral to one of two pediatric opthalmologists of the parent's choice, or arranges for the followup with other agencies who might be involved with the child and family. Children with immediate concerns and a questionable history of vision evaluation are the top priority when the opthalmologist makes a visit to the center.

Dental screenings occur annually and are provided through an arrangement with a children's dental clinic in the immediate area. A representative from the clinic comes to the center and screens each child for dental problems. The nurse then become responsible for followup information to the parent and to the appropriate agency. Accurate records are maintained of annual screenings and followup.

The hearing screenings are performed annually by the Communications Disorder Specialists (CDS) in this project. Visual Reinforcement Audiometry or play audiometry are two methods used. The nurse provides the followup information to parents. It is often appropriate to use this screening information for referrals and as collaborative information during regular communication with the child's physician. Before the purchase of the audiometer, the hearing screening arrangements were conducted with a local speech and hearing clinic. Although this arrangement was the best arrangement that could be made at the time, it became an unsuitable arrangement. The representative of the speech and hearing clinic could not come on the Northwest Center site with their department's instruments. Some of the staff at Northwest Center then had to make trips with the children to the clinic. This resulted in children not performing nearly as well during the administration of the procedures. Results of hearing screenings have been more satisfactory and yielded more information with the use of the audiometer on site. Children perform more satisfactorily and referrals are more accurately made.

Nutrition screenings are provided twice yearly for children. The nurse arranges for the 48 hour recall sheet to go to the parent. On this instrument, the parent is asked to provide written information about their child's food intake over the past two days. This information is coupled with similar information provided by the child's in-center teachers for the same period of time. When paired, the information provides a general idea of the typical patterns of food consumption and nutritional status of the individual child. This pattern is not completely representative of food patterns, but it does provide a guide for parents to examine their child's diet and provides useful information to the nurse and other health care providers.

After the nurse has complete information from both parents and teachers, she then arranges with a nutritionist from any agency that will cooperate for the technical evaluation. The cooperating agency is usually the local health department which employs a nutritionist as a consultant to various community agencies. The nurse then provides the followup information for the family. Sometimes this includes referral for a complete nutrition evaluation or a consultation for improving some aspects of the diet. This information is also used as the basis for informal conversation regarding the individual child and serves as a useful teaching tool for use with the family. The annual evaluation of services conducted by this program includes a question about nutrition evaluations. The consensus is that the families find the nutritional evaluation useful and wish to continue it. The nurse is responsible for all documentation and coordination of the process.

It is the opinion of this program that these health screenings are needed to maintain adequate health levels for all children. It is important for any other program wishing to implement such a component to be aware that what has been

established in this project has been accomplished with very little extra money. The nurse and project director are aware of the possibilities that exist in the community and are willing to make use of them in whatever way that can be.

Communicating Information

Other strategies include communicating child health information to state agencies which require annual information regarding immunization status of all children and establishing rapport with the epidemiology department of the local health department. Ordering health related pamphlets from the state printing office is a strategy that provides parents with information and becomes a useful teaching tool. These are free to agencies serving young children and are available to any agency wishing to use them.

The nurse in a full day program needs to be prepared to cope with people who are parents for the first time. Parenting is often compounded by the problems associated with having a child with a handicapping condition. There are other problems associated with a full day setting (i.e. usual early childhood diseases) that need the attention of a nurse. Families and staff need to be assured that good health procedures and practices have been implemented and are being monitored.

Health monitoring of each child includes quarterly recording of weights and heights on charts for each child. These growth grids provide the physician with information that is often helpful in developing a picture of the child's health. The nurse in this setting communicates this information to the child's primary health care provider. All comments from primary health care providers, regarding such practices, have been positive.

The arrangements for further medical and psychological testing, if needed, are made by the nurse. She is responsible for initiating the contact with the appropriate agency and following through with parents. Sometimes the procedures are complicated so this assistance is valuable.

The nurse is responsible for dealing with the daily accidents and emergencies that occur. Information concerning ill children is conveyed to families by the nurse who often isolates the child with her while the working parent makes other arrangements.

All medical procedures in the center are written in conjunction with any existing policies in effect at Northwest Center. The nurse is often requested to advise committees assigned the responsibility for formulating procedures and practices.

Another communication tool available to the nurse is the child's notebook that accompanies the child each day. Just as the therapists and teachers use this notebook to communicate in writing with families, so does the nurse. It provides a common document for the recording of important information between staff and families.

Staff Responsibilities

The nurse's role includes some responsibilities to the staff. She arranges annually for First Aid training, tuberculosis testing and other state health requirements that must be observed with individuals working with young children. She provides information, resources, consultation and some inservice training. The inservice training is provided formally at least once monthly and informally on a daily basis.

One important strategy includes interaction with the college and university nursing programs and arranging practicum sites for pediatric nursing students. This is coordinated on a quarterly basis and with a formal agreement between the participating institutions. Although the nurse arranges the in-center practicum for each student, both the Project Director and the nurse established the procedures for students to follow while participating in the program. This experience provides the student with direct observation of children, some assessment observation, direct interaction with the nurse and an opportunity for them to have a better understanding of the public health nursing position in a community based program. This project has found this arrangement to build positive relationships with the schools of nursing with several colleges and universities in this urban area.

EVALUATION

The evaluation of nursing services is viewed as a part of the overall program evaluation design. It is evaluated as a part of the whole program and as an independent component. The overall evaluation considers the financial impact of providing the services, the relationship of the nursing component to other services provided in the program and the manner in which the component remains consistent with overall program goals and objectives. This evaluation occurs on an annual basis and is conducted in conjunction with budget analysis of other program components.

The independent evaluation documents the comments of families who are using the services. Each set of screenings, consultation, and activities in which persons are engaged is evaluated with a written comment form. These data are compiled annually, synthesized and viewed as the basis for changing or adapting services to more fully reflect user needs. This information is included in an annual report produced for the agency board, as well as any agency providing financial support. Although this practice is time consuming and regarded by some staff persons as contributing to the reduction of services, it is important and therefore a continued practice. Each year, however, procedures are refined to require less time and reduce paperwork.

Nursing certification and licensing is another aspect for consideration. The nurse in this program is a registered nurse. Other programs may employ a licensed practical nurse, a pediatric nurse practitioner, or a registered nurse with a two year degree, rather than a four year degree. Generally, though not in all cases, certification or registration has to do with the training level of the nurse. The salary is usually dependent upon the classification (i.e. nurse practitioners usually command higher salaries than

nurses with a 2 year degree). These concerns are often related to the budget, although they are an element to be considered in the development of the health care component of a full day program. The level of information needed in this program to appropriately monitor the health status of children is considerable. The nurse must also monitor the adult population. Therefore, the requirement of a four year registered nurse is considered optimal.

BUDGET CONSIDERATIONS

In this project, the position of the nurse is financed by two sources. One source is the federal grant and the other is the allocation of funds from Northwest Center. As has been stated, the nurse's time is divided between 48 in-center children and their families and 250 adults who come onto the site daily. The greater portion of her time is spent in providing direct services to the children and families and a lesser portion of her time is spent in monitoring adult records and attending to emergencies of adults. Though the time allocation on each population is not equally divided, the agency considers the allocation of time appropriate to the population needs.

It may be prohibitive to employ a full-time registered nurse on a daily basis for a program serving only a small number of children. A survey conducted in this area revealed that only two other programs serving young children employed a full time nurse. Only one of these served handicapped children and that was on a part-day basis only.

This program finds services provided by the nurse to be integral and necessary for providing comprehensive services to children and families. It is this program's recommendation that if a program cannot afford a full time nurse to provide the services just described, then services need to be secured through consultation or contractual arrangement with other agencies. Tasks and activities might need to be modified and listed in order of priority, but they need to be secured in order to provide effective intervention and comprehensive services. This can sometimes be accomplished through a cooperative arrangement with a local health department. Another suggestion is that several programs share services and assume a portion of the expenses. Another possible arrangement is with a college or university which

might use the center as a pediatric practicum setting, or any combination of the previous suggestions. In order to provide comprehensive health services to handicapped children served in a full day setting it is strongly urged that a nurse, or some other medical personnel, establish procedures, monitoring them, and providing some direct services. If direct services are not possible, then an arrangement needs to exist whereby the services can be secured for the children in the child care setting. The services provided by the nurse in this program comprise a portion of the comprehensive services in a full day setting.

METHOD SUMMARY

(1) The use of a nurse in the multidisciplinary team to evaluate child health as a component of addressing the needs of the whole child.

(2) Direct child contact through screenings, family involvement, daily health monitoring, accurate and consistent charting and coordination with other agencies.

(3) Followup and referral to other health personnel for each child who has not the satisfactory medical information in file and when such information is vital to the intervention process.

(4) Providing resources and referral to staff and families.

(5) Using all available community resources to accomplish the goals and objectives of the nursing services component, which in this program, provides comprehensive services.

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Chapter VI

HOME BASED PROGRAMMING AS A COMPONENT IN AN INTEGRATED OR MAINSTREAMED PROGRAM

RATIONALE

The rationale for home-based programming is to provide appropriate options to parents. Parents who are not working outside of the home may or may not want an in-center program. They have the option of choosing a home-based program, a center-based program, or a combination of both of those. Flexibility is the key and an interest of the program in providing appropriate options for the family needs. The home-based component is the entry point for a family entering the program. The Family Services Coordinator makes the first contact with the family in their home after they have been referred to this program. After entry through the home-base component, a joint determination can be made as to the appropriateness of home-base programming, in-center programming, or a combination. These considerations are based on written criteria and are pertinent to the parents of a child with handicapping conditions.

Parents do not have to be working outside of the home to receive in-center services. However, that is often the case with the population in this urban area. Normally developing children go into the in-center program because they all have a working parent in the family. Parents of handicapped children have an option of either arrangement, though the in-center child usually has working parents.

A value of this program is that parents will be accepted at whatever level they enter this program and that all intervention efforts will be based upon the strengths of the child and parents in the family. It is a given in this program that all families have some strengths and that their needs usually center around lack of information. That lack of information may be in many areas (i.e. child development, use of community resources, health concerns). This program's goal is to provide information in whatever manner available consistent with program goals, family practices and which is considered appropriate by all participants.

METHODS OF SERVICE

The methods used in home-based programming include assessment of the child's needs, assessment of the family needs and individual programming for the child in the home with a family member present. Another method is coordination with in-center activities when appropriate. An important method is crisis counseling and networking with community resources to meet needs of the family that are sometimes beyond what this program can provide (i.e. indepth counseling, psychological testing). The methods also include a parenting-skills program for those parents who have been identified as mentally disabled, parent involvement opportunities that have an educational focus for all parents, and specialized programs to meet individual family needs. Opportunities for family involvement occur at many levels of interest.

Most of the home-based services are provided by the Family Services Coordinator (FSC). This person is responsible for all direct and indirect services.

STRATEGIES

Intake and Planning

After the referral, the Family Services Coordinator schedules a time for an initial visit in the child's home. During this visit the FSC completes all application forms in the intake packet. This includes eligibility with the State Developmental Disabilities agency for purposes of funding the services to child and family. If eligibility has not been established the family and FSC engage in the necessary steps to secure funding. Due to the length of time it takes to complete material in the intake packet and the need to collect the collaborative information, this first visit is most useful in establishing rapport and completing the intake process.

During the next meeting in the home, the FSC makes use of an informal checklist called the Parent Observation Index (Jobson & Anderson, 1981), which attempts to identify the needs of the family. Based upon this information and the other criteria, including parent working outside of the home, child health, therapy, educational needs, family desires, availability of in-center placements and other pertinent information, the joint decision is made as to the appropriateness of home-based programming. It is important to note that re-evaluation of family concerns is always being monitored, so that changes in family status and needs can be accommodated by this program.

Assessment Practices

When home-based programming has been established as the most appropriate method of service delivery to the child and family, the FSC then turns to asessment of the child during

subsequent visits. This is accomplished with the use of developmental checklists such as the ones used in the center and described in Services to Children chapter. Arrangement is made for a family member and the child to come into the center for a speech and language, educational and physical and/or occupational therapy evaluation to be conducted for the child. While these evaluations are in progress, the family member can be involved with the assessments and/or observing in the center. Emphasis is placed upon a connectedness with center and home-based programming. At this time, numbers of weekly visits are determined.

After these procedures have been observed, the FSC uses the weekly meetings with the in-center therapists to coordinate results of the assessment protocol and to begin to write the child's individual program. At this time, a determination is made as to who will provide the necessary therapy. Sometimes therapy consultation is provided by the FSC as primary communicator to the family and sometimes therapy services need to be secured from another agency. The FSC does not assume the role of the therapist, but facilitates the therapy in any number of ways.

During subsequent visits, the FSC is monitoring the needs of the entire family unit and determining with them when and where resources are needed. This process continues until the needs of the family unit changes. The child and family records follow the child into the center program when and if the child transfers to the center-based program. There is always a smooth transition and a linking of information at all levels.

As with in-center programming, all activities are documented according to an overall plan with the individual child and family. The IEP of the home-based child can as easily be used by a teaching team in the center. This is an important step because when the status of the child changes

and the child comes into the center the IEP can be adjusted and used by the in-center educational team. Flexibility in programming is an efficient use of time and strengthen the ties between the home and center based programs. As always, a value of this program is not to lock the parents into one mode of compliance or service delivery.

Other Intervention Practices

Other intervention strategies include a parenting-skills curriculum for those parents who have been identified as mentally disabled. This curriculum focuses on basic parenting skills needed when parenting a child, whether or not the child is handicapped. This particular curriculum guide (McKenna, 1982) was developed through this program, and addresses a need that was identified in the parent population occassionally served in this program. It focuses on eight basic areas of parenting and builds in a minimum level of skills in the identified areas. The curriculum guide is being field tested in 2 sites across the country and information is available by requesting it from this program. The important message here is not necessarily the development of the curriculum, but that the program identified a need and chose a strategy for meeting that need. Unfortunately, no other curriculum guide provided the information needed and was arranged in a format that was useful with this group of parents. The development of such a curriculum is time consuming and needs to have careful consideration before a program would consider committing time to do this.

Another strategy used in home-based programming is that of crisis counseling. The FSC is available as an immediate tool to be used while a more appropriate strategy for meeting the family crisis in an ongoing manner (i.e. a sudden separation or divorce, illness) is devised. The FSC is often called on to provide these services and it is her

responsibility to coordinate a timely and efficient plan of action with the family. Continuing followup is a part of this plan of action, until such time when the family problem or issue is sufficiently resolved. Sufficient resolution means that the family can manage the problem and it no longer is interfering with the routine of their life.

The evening parent meetings that occur in-center once monthly for the purposes of parent education and socialization is another strategy available to the FSC for those parents on home-based programs. This event is particularly useful for the family to use as a means of staying in touch with other families. The families on home-based programs use this event as a means to having experiences with other families who have normally developing children. The meetings also are an avenue for making acquaintances before the parent's child moves into the in-center program. The meetings are a useful arrangement for meeting parents of children when the home-based child has a combination in-center and home-based program.

The focus of the home-based program is to meet the ever changing needs of the family and the child within that family. This program wishes to remain flexible when addressing those needs.

Examples of Assessment Instruments

The Parent Observation Index (Jobson & Anderson, 1982) is used to help determine family needs as they relate to the child's handicapping condition. This instrument includes organization of the child's home environment, behavior management style, interaction with the child, attitudes and perceptions, coping abilities and emotional well-being, teaching style and parent relationship to staff and program. Other instruments, such as the Caldwell Home Inventory (Cal-

dwell, 1974), evaluate similar areas. The HOME yields a raw score and a way to manage data in its instructions, while the POI does not. However, the POI includes the skill areas that are described above, and arranges them in a way that is more useful when trying to design plans to meet the needs of parents. The HOME is a standardized instrument, where the POI is not. Still, this program has found the organization and format of the POI to be the more useful.

When specific needs surface, the Parent Behavior Progression (Bromwich, 1980) addresses some of these needs in its organization and content. Specifically, it addresses the interaction between parents and children and provides a scale divided into six levels for use in determining appropriate interventions. The scales have been recently revised (1983) and provide program information for children who are birth to 9 months and the second set of scales focuses on children 9 to 36 months. This instrument builds on the strengths of the parent and helps parents to build on the strengths of the child. It enhances pleasurable parent-child interaction crucial to the child's growth and helps parents to become more sensitive observers of their child. Implicit is the increase in satisfaction with the parenting role.

This program does not advocate the use of any particular instrument over the use of another. Rather, each is used for the particular focus for which it was written. It is difficult to find non-intrusive instruments to assist this program in helping parents grow in the areas they identify as needing assistance. The recommendation of this program is to use instruments that are found to be useful and to be flexible with them. The examples of instruments used in this program are only suggestions. They are used because of their ease in administration, non-intrusiveness, and they seem fairly non-judgmental about family life styles and customs. Also, the reason for choosing instruments that assist in evaluation of family needs is the program's desire

to be objective in dealing with this sensitive area. Subjective observation, based upon what the professional thinks she sees or hears, is often as inaccurate as expecting the family members to know what each member or family unit wants. Often times having an instrument that identifies areas of concern in which families usually need information makes the person working with the family feel more confident in making recommendations. The instrument can have the effect of reducing the subjectivity involved in intervening in other people's lives, no matter how well intentioned are the program and service provider. For the families, being able to see a written checklist helps them to know that because of other's needs, many like their own, information has been developed to assist them in decision making.

EVALUATION

Families

Strategies used by this program to evaluate the effectiveness of the home-based program relate to changes that occur as a result of intervention. The developmental checklists and standardized instruments described in the Services to Children chapter measure the child changes that occur as a result of the specific Individual Educational Program written for that child. The POI, the Caldwell, the Parent Behavior Progression, or the Parenting Skills Curriculum checklists all measure the changes that occur when programs have been designed for families, based upon baseline information from those instruments.

Using the assessment information as the baseline, and the information provided through family interactions with the FSC, the family and the FSC together build a program plan that will reflect changes in the areas identified. The changes will be measured with the assessment instruments. This program plan is developed and implemented within 40 program days after the family is a part of home-based component. Data, in the form of checkpoints of accomplishments and specific criteria assigned to behavioral objectives, are collected each week during the home visits. Five to six months after the initial program plan began, the assessments are re-administered. The change data, in the form of scores on the instruments, are used as a monitor of the individual family plan. These data help the family to see whether or not they are gaining the information they have identified themselves as needing. Ten months after the implementation of the program plan, the instruments are re-administered, final data are collected, and the plan is terminated. At that time, the family is either leaving the program or they are remaining and a new plan will be devised

with them. This individual family plan assists the family in seeing the changes that have occurred over the period of time. Each family plan is individual to that family.

This evaluation plan does not always work exactly as intended. People, and especially families, are not so predictable. However, every attempt is made to follow this plan, because it is more objective, it identifies how the activities will be monitored, and provides some basis for looking at family needs and changes over a period of 10 months. The 10 month period is used because a child and family usually is in this program for a full calendar year. Given the constraints of time, evaluations and report writing usually encompass 2 months. That leaves approximately 10 months for actually working on a program plan.

Families are involved in this process every step of the way. Information is included in a confidential file and they have the option of releasing it to another agency or having it remain in a closed file. This program is very careful not to discuss families with other agencies unless written release of information forms have been signed specifically for that conversation. Included at every step is a simple evaluation sheet, specific to that event. Families are asked to evaluate the events. The staff uses that information to make changes in procedures.

Program

Each year the usefulness of the instruments is evaluated as to how carefully they each measured the progress of the families in the identified areas. This evaluation is helpful in determining more appropriate instruments for assessing and planning with other families.

The home-base program is evaluated each year as to the number of families it is able to serve, the individual program plans it is able to complete, and the time factors involved and budget considerations. Based upon these comparisons, changes in the program occur. Each program year is compared to another, and when wide descrepancies occur in any area, the factors such as time involvement, instrumentation, budget issues and program goals are re-examined. The information yielded generally provides the impetus for change. Careful documentation of each component remains on file from year to year.

Parents/caregivers always have the prerogative of using this information. It is conducted with their knowledge and cooperation. Results of all homebased activities are plotted yearly on a matrix so that movement can be seen at a glance. This may sound sophisticated to some. However, it can be quite simply accomplished and really does what any good evaluation method should do -- that is to say, "is what we are doing really doing anything?" It is the opinion of this author that evaluation should provide the program manager and staff with real clues to the changes that need to take place or procedures that can remain the same. This project has struggled with this idea and, as we have remained committed to finding more useful ways, we have continued to be made aware of the value of evaluation.

It is important to include the families in the evaluation process. For example, after the intake process is completed, the family members complete a brief questionnaire focusing on their satisfaction with the process. Based upon this information, this program can determine how useful the procedures are and if and when it is necessary to make changes. These are really simple techniques and can be begun as simply as possible. When staff begins to read the comments and understand how the comments can be useful, then the process can begin to be more useful to all involved.

BUDGET CONSIDERATIONS

In this program there have been two FSC's working 30 hours weekly with their responsibilities divided between in-center families and home-based families. The FSC providing the home-based program has and continues to be funded primarily through the reinbursement of fees for services through Developmental Disabilities. The other FSC has been funded through the federal grant.

It was and continues to be important for this program to have clear program goals when considering services. For example, if budgetary constraints occur, it is not a matter of deleting a position or component, but rather looking at program goals and what supports those goals. Since this program desires a home-based component as a program option, high priority in the budget is given this position. Only if we eliminate this portion of the program would we not have the position. This project would not divide the work among others; that would not be an option.

This project has found that it can accomplish more work with families by having the 60 hours weekly shared by two persons who have divided responsibilities, but who could interchange responsibilities if needed. In this way, families in the center are receiving monitored services coordinated through the FSC, as well as those families on home-based services.

This project consistently serves 10 children on the home-based program. At present, the reimbursement fee is $22.00 for each 2 hour home visit. This amount supports the salary and benefits of the homebased person. Within this amount, the considerations have to be number of visits weekly, preparation time, report writing, travel time and time to staff with therapists in the center. Coordinating with other agencies is part of preparation time that can involve

many hours. To promote cost effectiveness, small groups of parents who may have common or specific needs have grouped together at different times. This is sometimes effective and sometimes not. This program recommends flexibility and continual reevaluation of strategies as they relate to the component goals and overall program goals.

METHODS SUMMARY

(1) The use of a multidisciplinary team approach, even when the FSC is the primary deliverer of services in the home.

(2) Involvement of the entire family unit, with an emphasis upon meeting the most urgent of the family needs, then focusing on the child's assessment and family program plan.

(3) Clearly defined procedures that have built in flexibility.

(4) A clearly defined philosophy of serving families, including focusing on the strengths of the family and moving from that point.

(5) Evaluation procedures that allow you to know that your program's strategies are working.

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Chapter VII

NUTRITION SERVICES IN THE INTEGRATED OR MAINSTREAMED EARLY CHILDHOOD PROGRAM

RATIONALE

The nutrition component of this Infant and Toddler program is considered essential and integral to providing comprehensive services. The premise is that feeding one's child, whether the child has handicapping conditions or is normally developing, is one of the areas of greatest concern for parents, caregivers, therapists and educators (Pipes, 1976). Concerns most commonly arising are behaviors related to foods, adaptations for handicapping conditions, food allergies, nutritional considerations and health related issues.

This program considers the nutritional concerns of the child basic to almost any other intervention that might occur with the family. This same statement is made with regard to the health component. It is this program's perspective that individual child health and current nutrition status must be addressed concurrently with the appropriate interventions in programming for each child.

METHODS OF SERVICE

The methods must include first identifying the elements of a nutrition component. This would include funding for the component, a statement of philosophy, how food is to be provided (i.e. cooked on site, brought in from off site), the type of food to be provided, specific objectives, and strategies for evaluation. When all of these questions have been answered and related to the overall program goals, then it is appropriate to look at the strategies for implementation.

This program discovered that these questions are often ignored and the food program begins by default, wandering on with procedures falling into place that become difficult to change in the future. It is possible and preferable to think through the issues, answer the questions and plan the nutrition component as carefully as the educational component. Within an already existing program, it is desirable for the program manager to evaluate the existing food program and make changes based upon consideration of the above issues.

STRATEGIES

Funding for the nutrition component in this program is through the U.S. Department of Agriculture (USDA), Child Nutrition program. An annual contract is negotiated with the USDA regional office. Reimbursement is dependent upon variables such as income levels of parents, types of meals served, whether or not commodities and donatibles are used or all food is purchased and a host of variables that are identified by USDA specific to each program. Monitoring of all activities is provided annually by the USDA regional office.

Philosophy

The philosophy of the nutrition component of this program is that children should become acquainted with a variety of nutritionally sound foods. The program achieves its objectives through the use of a vegetarian menu cycle. The rationale for use of a vegetarian cycle is based on quality of foods, cost of food preparation and the hope of dispelling myths about what foods children will and will not eat under the age of 3 years. Many food programs that use meat dishes for sources of protein and iron struggle with the costs of purchasing meat. They often buy cheaper and lesser quality meats and end up with the usual fare that is often represented on school menu cycle plans (i.e. hamburgers, macaroni and cheese, fish sticks). The idea of a vegetarian menu seems to offer a wider variety of options to the children, offers new ideas to the parents, permits the use of alternative sources of protein and iron and introduces food items in meal patterns that are not traditionally thought to be popular with young children.

At no time does this program seek to impose a value or particular style on the families. It is not the intent of this program to promote a value that vegetarianism is somehow better. All parents have been supportive of the vegetarian menu cycle and, with the exception of a few families, no families include vegetarian cooking in their homes. They are interested in the eating habits of their child while the child is in the center and continue to provide meat as a major source of protein and iron in their own homes. What the introduction of a vegetarian menu has done for families is to increase awareness of what their children will try. Parents are surprised to discover that their child ate a new item that they felt they might not have successfully introduced at home. For this reason alone, the use of a vegetarian menu cycle has been useful. This is as true for the handicapped child as for the normally developing child and sometimes even more so. The only significant food distinction made between normally developing children and handicapped children is usually due to allergies and oral-motor problems.

Objectives

The objectives of the nutrition component in this program are to provide quality foods at meal time that meet USDA guidelines, to increase child tolerance for variety and textures that are appropriate to their developmental level, and to increase parent awareness of nutritionally sound foods. Additionally, the objectives are intended to provide opportunities for managing food behaviors in children, to assist parents in adaptation for the child's special needs, to foster independent and functional eating skills, and to evaluate periodically the overall nutritional intake of the child.

After determining that the philosophy is consistent with overall program goals, the next strategy is to determine what is the most cost efficient procedure to secure the services. This program chooses to have the food prepared on site by a cook. The cook's salary is funded through a grant to this agency and partial reimbursement from USDA. It is important to note that this position is a high priority in the nutrition component. If funds cannot sustain the position of the cook who cooks on site, then the goals of the food program would have to be reconsidered and would possibly change.

Service Plan

The cook in this program prepares and serves food within a 4 hour period each day. This seems an adequate amount of time for the weekly shopping, daily preparation, cooking, serving and record keeping. Although it is sometimes difficult to secure a person with a commitment to the program who wants to work only 4 hours, this program has managed to do so for three years. Keeping the time limited to 4 hours allows this program to continue to provide two meals daily to 48 children and to be able to afford to do so.

The meals are served family style to encourage independent actions appropriate to child developmental levels. Trays are taken by the classroom aides to individual rooms. Each family unit eats in its own room. This is a preferred arrangement for children under three years. It appears, through observation, that larger groups of children increase noise level. Sometimes, older children exhibit inappropriate behaviors in older children which makes it more difficult for therapists to focus on particular feeding objectives for individual children. This also decreases the personal and family orientation that is important to this program. It is the recommendation of this program that, if

meals are to be served to young children under three in a group setting, that they be served in groups as small as possible.

The developmentally integrated family unit groups (described in the Services to Children chapter) assist in promoting the goals of the food program. The small groups (8 children) at different developmental levels allow the children with higher level skills to model appropriate eating behaviors. Therapists are better able to focus on specific children with fewer distractions, educators are better able to focus on children's behaviors and children enjoy each other more in a more relaxed atmosphere. Also, because of the different developmental levels, some children eat independently, allowing the educators and therapists a higher ratio of adults to children who need closer supervision.

The menu planning cycle runs 40 days so that a menu is repeated every 40 days. This gives a wide variety of foods to children. Because all menu cycles are planned for groups of 12, 36 or 48 children and all recipes are attached to each cycle, the weekly preparation time is considerably reduced.

Procedures for purchasing foods, comparisons of prices and quantities, and their relationship to the overall food program are revised annually. This program has this information available upon request. The complete manual is too large to be included in this guide. This program annually compares the cost ratio of the vegetarian cycle to a comparable menu cycle that would include meat items. The cost is usually slightly lower for the vegetarian menus. The variety of food items offered in the vegetarian menu plans seems to be wider.

Family Information

Another strategy to be mentioned here is a practice this program has established and continues. That is the practice of having parents bring an afternoon snack rather than prepare one in the center.

The program finds this practice to be valuable in providing an educational opportunity for parents. The family member who is responsible for preparation of the afternoon snack has the opportunity to be involved with the child's diet. All responsibility is not relinquished to the center for food preparation. This practice also allows the staff to be aware of what information a family might need regarding appropriate foods for their child. It is common that the continued absence of an afternoon snack results in uncovering another problem with the family. Frequently, the inappropriateness of snacks (i.e. Fritos, popcorn, cookies), provides the information to staff they need to increase information to families about more appropriate and nutritious food.

Information to families is often in the form of nutrition pamphlets that come from the Department of Agriculture and are available through this state's Department of Social and Health Services, the local Dairy Council and other agencies. Direct one-to-one counseling, referrals to other agencies or persons for nutritional evaluations are a part of providing information to families. The procedures discussed in these paragraphs are suggestions for ways that work for this program in involving families in understanding the value of nutrition in their child's life. It is an ongoing process and new practices are always in the experimental stage.

One team of educators chooses to have one day a month when they request a specific food item of the families in their

room. These food items are a part of a new recipe used as the basis for afternoon snacks in that room. The children assist in preparation, then the recipe and description of food preparation go to the family. Interesting results are that some parents did not seem to know that a young child could eat plain yogurt (or would) and that rice crackers are unsalted and make great teething biscuits. One parent reported in surprise that raw vegetables are less expensive as a snack than the pre-packaged item he had been buying. Interestingly, several of the parents mentioned in these examples are upper middle income and two parent families whose knowledge about these issues are not related to their socio economic status. Lack of information about nutrition is seen in all levels of socio economic groups in this center.

Significant Points to Consider

Again, at no time does this program urge or suggest that families adopt a vegetarian meal pattern. No family has ever objected to it either. Currently, 2 families have children who have allergies to dairy products, so on the days when dairy products are the main source of protein and iron, the parent sends another food item that can be substituted for the dairy product. This program remains flexible to family needs.

Throughout the vegetarian cycle, there is an interest in observing the cultural food values that surface as a result of the different ethnic groups represented in this program. There is at least one menu plan in the 40 day cycle that is representative of the cultural values of the different ethnic groups represented in the center. The program asked the families to assist in designing some menu plans and these ideas were incorporated.

Some of the most interesting findings while using a vegetarian menu plan have to do with the tolerance for certain foods by most children. There are some surprises. Some favorite protein and iron components of a meal are Lentil Barley Bake, Cheese Souffle, Broccolei Cheese Pie, and Green Potatoes. Favorite vegetables are brussel sprouts, carrots, cauliflour and zucchini. A variation on the theme of peanut butter is the all time favorite Peanut Butter Raisin Balls, rolled in wheat germ. A favorite snack is Chedder Cheese Puffs and rice cakes. Whole grain cereals and fresh blueberries or other fresh fruit are favorite breakfast items. The all time favorite is freshly made pizza with vegetables on the top.

All of the foods just described have ingredients that meet the USDA requirements for that portion of the meal. All foods are consumed by all children, except those who have particular food allergies. Even pizza can be blended in the cuisinart to the desired consistency for a particular child. Because the food is nutritionally sound, parents of young babies choose these foods as the first strained foods for their child, rather than commrecially prepared baby foods.

At each meal, the considerations are texture, a combination of finger foods and spoon foods, color and complimentary tastes. These considerations take thoughtful preparation and planning.

Due to the number of oral motor problems, lack of functional self-help skills for some children and the allergies of some children, there are a fair number of adaptations that need to be made. There are a number of foods that need to be blended daily to different consistencies, depending on the child's oral motor needs and developmental stage. The cook finds a commercial model of the cuisinart to be useful in blending foods to the appropriate consistency for each child. Allergies to certain foods are carefully documented

and posted for daily consideration. The important message to be conveyed is that this program has not so far found a problem that is related to the nutritional component that can not be resolved in some way. It is a challenge providing appropriate and interesting foods to the children in an integrated program, while providing information and education for families. This program meets these challenges in the ways described in this chapter.

EVALUATION

Semi-annual nutrition assessments are conducted with a 48 hour recall instrument for all children whose family is willing to participate. Generally, two thirds of all families of children enrolled in the program participate. The recall instrument is described in the Nursing Services chapter.

The individual nutrition evaluations are useful to parents because they provide information about whether or not the foods they are feeding their children are adequately nutritious. They gain information about what they need to add, delete, and serve more of, and what it all means for their child's health. This information is most useful for those parents whose child is on medications that might affect the absorption of certain nutrients (i.e. iron absorption and the seizure medication dilantin). The specific nutrition information provides a basis for discussion of other issues related to food, such as behaviors, expectations of parents regarding those behaviors and how to manage behaviors related to food and eating.

Semi-annually the cook evaluates the prices and purchase arrangement of foods and determines if the arrangements are compatible with program needs. Annually, the procedures in the nutrition component are evaluated as to their effectiveness, cost efficiency and compatibility with program goals. Changes are made, if necessary, and the changes are based upon the information generated from these questions. Information is compared with each year's scope of services and program goals.

Contractual agreement with the USDA requires strict accounting procedures. This program uses those procedures to evaluate record keeping, food portions, food variety and

amounts, cost accounting and service delivery. Printed guidelines are available for programs involved in the USDA Child Care Nutrition program.

BUDGET CONSIDERATIONS

The first consideration is to determine what priority the nutrition component occupies in your program. If it is an important component and is consistent with your program goals, then finding funds to support the component becomes a high priority.

The nutrition component in this program has its food costs reimbursed approximately 80% through the USDA program. Northwest Center is responsible for securing funds to support the cook position.

Options for funding the cook's position include: increasing parent tuition to cover the amount necessary for the salaried position; writing a special grant request to cover the salary; using other grant options (i.e., Title 1, which provides ancillary services to handicapped children); or a combination of any of the above.

Although the USDA has many requirements, participation in this program can make the difference between providing a child care food program in your own center and not providing one.

METHODS SUMMARY

(1) Establish nutrition goals that are compatible with goals in other components of the program.

(2) Explore funding options and decide which will fund the type of nutrition component your program desires to provide.

(3) Explore philosophical issues and settle on those that are compatible with your program. Some of these are menu plans, serving styles, types of foods and other considerations unique to your program.

(4) If a position is created that requires an individual to do the cooking, select an individual for the position who can work within the philosophy of program.

(5) Plan strategies for determining how and why the program is working. Make the evaluation work for your program -- not be extra work.

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Chapter VIII

FAMILY INVOLVEMENT IN AN INTEGRATED OR MAINSTREAMED EARLY CHILDHOOD PROGRAM

RATIONALE

Any program providing full day care for children has unique problems in involving families whose members work outside the home. This program's philosophy is that all families do want to be involved with their children as much as time permits. This program assumes that families want information about growth and development. They need information about parenting skills, special problems they face in having a handicapped child and a host of problems that are ever present in the parenting process. In this program, family involvement can be in any form compatible with a family's lifestyle, parenting philosophy, personal time and their current level of personal and emotional adjustment. It is a premise of this program to accept families at whatever level and to move with them at their own pace as they search for information to positively enhance the parenting experience.

METHODS OF INVOLVEMENT

All methods of involvement need to be consistent with the goals of the program. In this program the goal of family involvement is to provide options that fit individual families. An objective for reaching that goal is to have the families function as independently as possible with the information given them. The staff of this program is ready to provide assistance at each step, but the end result is the desire that the families will independently use the information in making good decisions about their children and their own involvement in this program.

Methods of family involvement in this program include some of the following opportunities:

Observation and participation in the child's classroom is encouraged whenever possible and in a variety of ways that fit the individual parent. Monthly evening parent meetings provide a way of involvement for some persons. Home visitations are an option for some families. Home-based programming is an option for other families. Individual assessment and programming for families who need assistance with identified problems is yet another method. Participation on a parent advisory committee is an option for some parents. An opportunity to participate in the communication system that exists in the center is encouraged for all parents, no matter what other options they may choose.

STRATEGIES

Classroom Participation

Participation by family members in the child's classroom activities is encouraged because it supports the idea that the child is an individual who interacts in her own unique way with other persons. Classroom participation can help parents to see behaviors and skills they may not see at home. The reverse of this is true for the staff working with the child in the daily environment. This is as important for parents of handicapped children as it is for parents of normally developing children. If there is a particular adaptation made for a handicapped child, the parent can receive demonstration and assistance for using the information in the home environment.

The same comment can be made for the therapy sessions. Often times, the therapists are working in the classroom so the parent can view this session informally and question when necessary.

The usual way in which this strategy is implemented is for the teaching team and Family Services Coordinator to use information the parent shared during the intake interview. This is a developmental interview that has information about the child and family including constraints of the parent's work schedule.

This step is really important. The teaching team may feel that parent observation and participation is critical. The parent's work schedule may not permit time for classroom participation. The team does not want to make the parent feel guilty by insisting that this activity occur, so sensitivity to the particular situation is critical. The strategy involves another step and that is to say, "what has

been described might be the ideal situation, however it can't happen at this time. Let's see what can work for you." The staff and parents need to work together to design a workable plan.

Classroom participation can be in many forms. A parent can learn a lot from a 10 minute observation. Often it is easier to get off work 10 minutes early than to try for a whole day. Sometimes bringing the child into the classroom earlier in the morning can make the parent feel she has spent time in her child's classroom. Some parents come on their lunch hours. Some, to our surprise, are able to get time off from work for a classroom activity.

Even the 15 minutes when the parent brings the child to the center can be a time for involvement. If a child is in attendance each day, that can mean five hours a month spent in the classroom.

Each classroom functions individually. Some have special parties for children and parents at the end of a month, some have special snacks to which parents contribute, some have special work parties and some even try more structured activities. In this program, any appropriate activity is encouraged. Classroom events that support the "family unit grouping" in the center semm to be popular. Families seem to prefer small groupings to large gatherigs of parents.

There is a wide variety of family characteristics represented in this program. Some parents are mentally disabled themselves; some are single parent families; some are two parent families where all members work; some are foster parents. Involvement strategies must work for the variety of family lifestyles and philosophies.

Due to the unique needs of each family, all involvement activities are documented in writing and remain in the child

or family's personal and confidential file. This information can be instrumental in helping the staff and family to know they are assisting each other in appropriate ways.

Sometimes there are parents who are required to participate in the center activities as a condition of custody with their child. Although this event occurs infrequently, this is viewed as a positive learning experience and staff tries to make it work for the family. The purpose of the participation is to strengthen parenting skills and increase appropriate parent child interaction. Staff must structure activities carefully and plan time to interact with families at their level.

Classroom participation and observation is one option for parent involvement. This program finds it possible to focus on individual family needs and to structure opportunities accordingly. Classroom involvement can be in a variety of ways. Staff and parents can expand their vision of what classroom participation can be.

Evening Parent Meetings

Many early childhood programs offer parent meetings. This program offers the evening meetings as educational and social events for parents. For those parents who work outside the home, these meetings can be a great option for them or a problem. The perspective each family takes regarding evening meetings often depends on their enjoyment of group meetings, how they feel at the end of the day, what the evening topic is and the availability of child care during the meeting. The use of this option is individual to each family.

This program operates on a 12 month timeline. Each June, before some families leave for vacations, a needs assessment

is conducted with each family. The purpose of the questionnaire is to elicit information from them about their concerns for their child; their need for resources in the community; what did and did not work for them in the current year; what topics they want in evening meetings; or even if they want meetings and what they want in the form of parent involvement for the following year.

When the information is returned, the staff synthesizes the information and gives their own input about program topics. After final decisions are reached about what the topics will be, the program director and Family Services Coordinator are responsible for selecting presentors for each topic. Information about persons who present information on a variety of subjects is kept in a resource file. This file increases each year, making selection easier due to the wide variety of persons available.

Presentors for these meetings are usually not paid a fee for their presentation or offered an honorarium. Generally, this is because there is a reciprocal arrangement with staff from this program presenting in other settings.

It is also important for staff members to offer their own perceptions of who should provide information and what that information should be. A good example of this is the issue of children leaving this program at the end of a year. The information about what is available for children who are leaving, whether normally developing or handicapped, is important information for those parents. However, on the initial needs assessment, parents do not always list that issue as a high priority. The staff needs to anticipate that parents will need this information and make suggestions for a parent meeting to address it. In this program, that meeting is one of the most well attended of the entire year. Professionals have a responsibility to share their expertise as well as listening and responding to parent concerns.

After the annual agenda of parent meetings is planned, follow up letters are sent to presentors. The purpose is to acquaint them with more program information and to insure that the presentor puts the date on her or his calendar. Printed agendas are mailed to the families so that they have them for reference throughout the year.

This program suggests this amount of initial planning as being useful. Each month, only a reminder call to the presentor is needed. Parents are reminded through the center newsletter that have RSVP notes attached. This plan reduces the amount of energy the staff must spend on organizing. In our experience, the parents appreciate this systematic planning. They know what to expect each month and can plan accordingly.

Usually before the evening presentation, a potluck dinner is shared by those staff persons and parents who choose to bring a food item. This is a lively time for socialization. Many friendships are formed and ideas shared during this time, between both populations of parents.

At the end of the meeting, all parents are asked to participate in evaluating the meeting. The one page questionnaire includes questions such as: will this information be used and how? Did you have the opportunity to interact with other parents? What is your overall rating? Would you want this session repeated next year? There are other questions, but the intent is to understand how the integrated parent population mutually uses the information presented in the meetings. It is important to mention that whatever topics are covered, they are from the perspective that all parents need the information, and that each parent has to adapt the information for her child's stage of development and/or handicapping condition.

Some of the topics covered have been in the areas of behavior management, child abuse, normal growth and development, the development of normal communication skills, play skills in children and a host of other concerns. One of the most popular was the presentation on sexual abuse of children and how parents can teach children not be victims. Our data indicate that the meeting where attendance was the greatest was the Fall orientation presentation. Next was the transition issues meeting. Attendance varies with subject interest and the family interest in group participation.

The evening parent meetings are but one option for family participation in this program.

Home Visitations

The home visitations are described in the Home Base chapter. For the family in the center program, home visitations is an option for families. Classroom teachers and therapists can be involved in that process, but it is more difficult to arrange times. Most parents are working parents. Teachers and therapists are spending their time in the center program working with children of those parents. All persons have the visitations as an option, however the staff tries to e sensitive to the intrusion on the parent's personal time. Efforts are made to keep the number of people participating in those home visits to a minimum.

Teachers, parents and staff persons are asked to evaluate each visit to determine if it is meeting their needs. The purpose of the visit is clarified each time. Sometimes it is social and sometimes program related. The results are always positive from both parties.

The strategy this program has used to allow staff persons the option of home visitations for those families who choose

that option is still in operation. Each staff person is allotted a certain number of hours to be used for visitations. When the staff member accrues eight hours, he receives eight hours of compensatory time and a substitute is hired for that teaching day.

Most home visits are made in the evening on the staff person's time. This is not always the case but often it is. Staff persons and families are careful in exercising this option. In this program, less than 15% of the families exercise the option. Each case is approached individually and evaluated. The option works well for those persons for whom it it intended.

Involvement Through Child Assessment Procedures

Another strategy to provide families with options is that of being a part of the child's assessment process (described in the Services to Children chapter). Since the results of this process become the basis for forming the child's individual program plan, it is one of the most important events. Family members are encouraged to participate in the assessment whenever possible. This is difficult for working parents if it can not be scheduled around their work hours. The reality is that therapists and teachers also have many children to assess and must fit all assessments into the day.

Involving parents in the evaluation process is challenging but in most staff member's opinion beneficial to everyone. This program encourages a multidisciplinary approach to the child's program, so coordinating all team members can be a constraint to moving all team participants to a family's home for assessments. Materials are usually in the center and not that easy to move elsewhere. Often times at the end of the day, parents do not want anyone in their home for

such an important event. So, careful planning on the part of families and staff to achieve family participation in the assessment process is critical. Yet, as has been stated, the effort is beneficial to families.

Formally conferences are scheduled a minimum of three times a year. These conferences include written evaluations by the parents. A family member is encouraged to attend all three conferences. A family member is required to attend the individual program plan conference. Program data show that approximately 85% attend all conferences.

Participation in assessments and conferencing are options for families. These options are exercised by the majority of families in this program.

Parent Advisory Committee

A parent advisory committee exists to promote interest in the program with the public, act in an advisory capacity with the program director and to share information with all parents in the program.

The committee is comprised of five community representatives (pediatrician, media, attorney) and five parents whose children are enrolled in the program or have been in the program. There are both parents of handicapped children and parents of normally developing children. The committee meets bimonthly and sometimes monthly for special events. The committee must relate to other programs in Northwest Center, so participation on this committee is a learning experience for a participating parent. This option is a good one for individual parents who enjoy this type of involvement and decision making.

The Communications System

An important option for families to become involved in is the communications system that operates in the center. In a program with many people talking to one another and exchanging information daily, it is critical to have a system that is understood by all participants. Following is a description of some strategies that work in the communication system in this center.

Staff and families find that defining the communication process is as important as any other element of the program. The sender and receiver of information must both understand their roles if the system is to work. In this program, we have defined who will be the senders and receivers of information. Usually, the team teachers are the prime communicators of information to the home. One reason for this is to have continuity with families. Since a family may also be interacting with a therapist, a nurse and even another teacher, it can become confusing to have all persons communicating important bits of information. This also creates confusion for families about who is to listen to them. In the communication system existing in this program, the goal is that all communication about the parent's child will flow through the teachers. There is then one central point of information processing.

That doesn't mean a parent can't go to a therapist or nurse to discuss an issue, but what it does mean is that the therapist or nurse has a responsibility for communicating the content of the conversation to the teachers. Some conversations may be confidential, and then the confidentiality is respected. A central point of information processing and dissemination is useful for keeping the confusion at a minimum. It also eliminates the duplication of information sent or received by both parties. An example of this

is a family who brings the child into the center in the morning and leaves medication with the nurse, giving her all of the pertinent information. The nurse reminds the parent to mention to the teacher the child's use of the medication. The teacher is then prepared to deal with the consequences of that medication in the classroom throughout the day. The nurse is also responsible for following up with other people who are involved with the child. This may seem a minor issue but it is not. Surveys in this program continually ask questions about the communications issue. Most of the time parents who return the surveys respond positively to the question of not feeling lost in the shuffle. They indicate that they feel listened to as well as having a mechanism for being being an active participant in the process.

In this program a most useful strategy for two way communication is through a notebook. It is placed in the child's tote bag that is brought with the child to the center each day. The parents and staff each read and write in the notebooks and they are returned home each day. Each knows that the other has read the notes because each is initialed by the reader. These notebooks also serve as long-term diaries of development of parents and children. Parents can look back over the books and monitor their own changes over periods of time. Many parents report they keep the books and refer to them. The notebooks are simple, efficient and most effective for communication and a form of involvement for families. Though there are a few families who consistently are intermittent in their use of this tool, at least 6-7 of the parents in each classroom of eight children use this system for communication and involvement.

This system also encourages independent use of resources by the families. For example, if the parent asks a staff person "how did my child do today" and that staff person did not interact with that child frequently during the day, the

staff person can respond in a variety of ways. The preferred response in this program is "It would be really good to check that in your child's notebook." By answering in this manner, the staff person is promoting the use of the communication system and placing responsibility for getting clear information with the parents. It also has the effect of strengthening the bonds between the primary teachers and parents.

In the communication system another strategy for contact and involvement is by phone. Some staff persons and families speak frequently by phone. This may sound simplistic, however a regularly scheduled time to talk requires planning and commitment from both parties. This may work for some families and may be their best option for a period of time.

The child's therapy sessions may be the focal point of involvement. Again this may be more difficult for the working parent. However, written communication about these therapy sessions is placed in the notebooks regularly so that families know what happens. The therapy session can be a time when parents really involve themselves with this aspect of their child's program plan or it can be a little understood part of their child's plan. The option for parent involvement is always extended to them by the therapists. The therapists would much prefer a parent or family member be present in the sessions, simply because they feel strongly about carry over from therapy session to the home environment.

Some parents choose the therapy sessions as a major area of involvement and some do not. Written comments on evaluation forms indicate non-involvement by parents for reasons that include; "it's too depressing; I have difficulty watching; it's difficult to always carry over and there are other more important considerations right now." Whatever the reasons, the staff respect the parent's decision. However, it is

fair to say therapists feel strongly about parent involvement in therapy. In this program participation in therapy sessions is an option, not a requirement.

Other Options

Another less formal option is the bimonthly work parties. These work parties are participated in by both staff and parents but mostly parents. They occur for the purposes of cleaning, painting, repairing and attending to those maintenance issues that can not be addressed each day in the center. A Saturday will be set aside and a time period of four hours designated as the official "work party" time. Usually a core group of parents is in attendance during each work party. These families are frequently people who aren't regular participants in other events. The work the parents perform is needed and much appreciated by the staff. Family work parties are not to be overlooked as opportunities for involvement.

A parent newsletter is a weekly feature of this program. This letter goes to all families and any family member can use this newsletter as a vehicle for communication. The weekly publication announces upcoming events. It announces what is occurring that week in the peer groups and also includes any useful legislative or political information regarding young children. Families and staff share in making contributions to the newsletter. Parents often contribute information about child development they wish to share with other parents. If they have read a new article they may want to share it. The weekly menu announcing the center's meals accompanies this letter. Parents can use all information that comes through the newsletter as a basis for discussion and action with other people.

Chapter VIII FAMILY INVOLVEMENT

The Parent Handbook is another component of the communication system. The families have the handbook from the time of the initial intake into the program. They are encouraged by staff to use the book as a reference for themselves. Many questions regarding common issues in the center are asked over and over. The staff use this opportunity to refer the parent back to the parent book. By being consistent with this practice, the staff is also encouraging independent use of information. This is consistent with family goals in this program.

EVALUATION

The success and appropriateness of the family involvement component is measured by the responses of the families in the evaluation forms they are encouraged to complete. These evaluation forms are requested each time families participate in events. The data generated from these forms indicate the appropriateness and satisfaction of events.

Attendance at events is documented and considered but by itself is not the measure of whether or not to continue an event. More importantly, the combination of different data is the criterion by which changes are made. These factors are attendance, satisfaction, parents of handicapped or non-handicapped children, and continuing requests for the options.

The "family program questionnaire" is sent to parents annually. Much information about what will be the involvement options for the following year is determined from this questionnaire. This information, along with staff input and conversations with families, is helpful in formulating the involvement options.

Brief questionnaires following each parent conference and other activities are requested of families. The information generated from these surveys is valuable in determining what program options might be available. All information is synthesized on a yearly basis and program changes might occur as a result of the information.

For purposes of evaluating the family's perspective of the entire program, a final program evaluation form is requested of the parents. This short evaluation format has key questions about basic program elements. The parents are asked to evaluate the program elements with regard to their expe-

riences while being a part of the program. This information is valuable for evaluating the program from a broader perspective. Attention is paid to the answers at the end of each program year and the information is used as a basis for consideration of future program changes.

This program continually seeks methods of family involvement that are useful and satisfying to families. One of the most difficult issues for staff persons in evaluating this component has to do with the full-day program. There is always much staff conversation concerning what constitutes appropriate family involvement. A complicating factor is that the view of intervention with families is changing and there is no effective model to which to turn for working with families in a full-day program. Certainly there is no well established model for an integrated program. Both staff persons and families are seeking ways that work for both. Parents need to be recognized for their contributions, in whatever way that may be, and professionals have the same needs. This program will continue to search for more effective and useful methods that are mutually satisfying to both parties. The one suggestion that both parties agree upon at this point is that an individual approach to family involvement is essential.

METHODS SUMMARY

Important points to consider are as follows:

(1) Determine what families want and need by asking them, document the information and design involvement options that are compatible with their wishes.

(2) Use the information of professionals in a way that is harmonious with individual family needs. Professionals have an obligation to exercise their professional judgment about issues and to respond sensitively to the family.

(3) Establish and implement a well understood communication system in your program. Identify procedures for senders and receivers to use.

(4) Use parent evaluations as a basis for any changes that might effect the program involvement opportunities and planning. Encourage the use of the evaluation format by making it really simple.

(5) Individualize the opportunities for families. As an individual professional and staff person, broaden the definition of what family involvement can be.

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Chapter IX

STAFF TRAINING IN A MAINSTREAMED OR INTEGRATED EARLY CHILDHOOD PROGRAM

RATIONALE

The professional staff of an integrated or mainstreamed program needs to be selected with care. It is not enough to hire teachers or therapists with appropriate credentials and expect then to function adequately in such an unusual setting. The purpose of this chapter is to focus on some of the desired staff characteristics and outline elements helpful to those responsible for hiring and training staff. It will chronicle the major discoveries of this program regarding staff development and training.

METHODS

A careful and thoughtful review of programs goals is an essential starting place for staff selection or training. Staff persons already in the program or those who might be hired must recognize that expectations are different in an integrated program. They also have a right to know what will be expected of them in an integrated program. They need to know how their skills will be viewed relative to these new expectations and how those skills will fit into an integrated program. Clearly, the goals of the program will dictate the staffing competencies required.

Once the program goals and objectives have been clarified, specific staff characteristics can be identified. For ex-

ample, this program deals with children in groups of eight. Two instructional staff members are required to maintain a 1:4 teacher/child ratio. Since these teachers will be working closely together, it is important that their teaching philosophies be compatible. The composition of such a team must also be considered. Will there be a teacher and aide, two certified teachers, an early childhood specialist and special educator or some other arrangement. This is an example of the issues to be considered.

The third method is to determine the specific characteristics needed for professionals working in an integrated program. Can people be recruited who have the specific skills and attitudes needed? What training is needed to assist existing staff persons to acquire the identified skills?

The fourth method is to identify or develop an ongoing in-service training plan that will assist staff members in their growth and development. The methods used in this project, described later, allow the staff to have input into the training plans which seems to have some benefits.

STRATEGIES

Program Goals and Staff Considerations

The first method, a consideration and review of program goals and philosophy can be accomplished through the following strategies:

The person responsible, usually the program director, clearly articulates program goals and commits them to writing. Staff members need to refer to these periodically, particularly when program implementation becomes difficult.

The population to be served is clearly identified. Care is taken to assure a good match between the needs of children to be served and the services offered.

It is very important that the staff clearly understand the goals, objectives and philosophies of the program. If this is done well, it will eliminate the need to justify each action taken on a day to day basis. It builds credibility with the staff when the administrator is able to say "this particular event can't take place because it is not compatible with present program goals. If we want to have that event occur we'll have to modify the goals at the next re-evaluation period."

The administrator needs to be able to clearly identify the roles of the manager and staff and initiate team approaches.

The administrator must be able to follow legal and professional guidelines while modifying the program to meet current federal and state laws, rules and regulations. Involvement in the community, fiscal management, program evaluation and dissemination of information must all be consistent with and reflective of the program philosophy and goals.

Staff Selection

The second method, determining what staff is necessary to accomplish the outlined program goals, has been accomplished in this program by the following strategies:

This program determined that the underlying educational philosophy would be a cognitive-developmental approach. This is described in the section on philosophical and educational considerations. The cognitive-developmental approach dictated some of the program parameters. We decided, given the projected enrollment, that there would be six developmentally integrated groups. Each group would have two teachers. These would be a special educator and an early childhood teacher which provided the combination of skills needed. There would be two speech therapists to respond to the communication delays in children and physical and occupational therapists to respond to the physical problems of children. There would be a nurse to monitor health concerns, a cook for the nutrition component and a social service person to deal with family concerns. The decision was made to coordinate all of these services through a multidisciplinary team approach.

Next, the program manager determined what competencies would be needed in each staff member so the program design could be carried out.

An example of this is in the educational approach. Since it is defined as being a cognitive-developmental approach, every activity should support that theoretical position. This means that staff persons must understand and accept this theoretical position and reconcile their teaching philosophies to it. There is still considerable room for one's own teaching or therapy style but it is important for

each person to understand the approach and what it means for the implementation of her own philosophy. For example, in this program, if a teacher's philosophy was more consistent with teacher-directed activities and less with child initiated activities, then he or she would probably not be comfortable with this program. In this program, the child initiates most activities and the teacher is the facilitator of the learning experience. The expectation is that teachers will understand this approach and adopt a teaching philosophy consistent with it. It would be counter productive if a staff person spent an inordinate amount of time trying to change the system at this point.

The initial staff design was to pair a special educator with an early childhood specialist in each class for the purpose of blending the two perspectives. These two professionals typically have different academic preparation and therefore bring different skills to the teaching situation. In this situation, where both normally developing and handicapped infants and toddlers are served, it is important to have the two perspectives represented. Unfortunately, labor market considerations do not always allow staffing in the most optimal patterns. At the present time, this program does not have the ideal pairing in each class.

In teams where the desired arrangement exists, there is a continual and healthy dialogue with negotiation of teaching procedures and practices. Some of this occurs in classes staffed by two special education teachers but not as much.

In this program, the therapists are expected to provide services in the child's classroom to the greatest extent possible. This is a clearly defined component of the program design. Therefore, a therapist who is not comfortable with this expectation probably would not be appropriate for this program. Teachers, therapists, social workers and any other staff members involved with the program must be a part

of a multidisciplinary team. The team approach means that each staff person is respected for his or her special area of expertise and brings those skills to the team. During staffings, for purposes of program planning for individual children, there is a real effort to bring all perspectives into decision making that concern the child and family.

What does this mean for a child-care program that has been serving normally developing children? A program beginning to include handicapped children might not hire full-time multidisciplinary specialists but they should be available on a consultant basis. There should be close communication between teachers, administrators, parents and others involved with disabled children from the very beginning. Such communication is important when people from different disciplines are expected to work effectively together.

Sometimes in early intervention programs feelings of "ownership" develop for specific children. Staff people begin to think they are more responsible for some children than others. The team approach used in this program assists each staff person to understand their responsibilities to all children in the program.

Again, it is important to note that any changes for a staff can be difficult. It takes time and practice to encourage people to accept a new approach and to assist them in understanding its potential benefits. Key people have to really believe in the changes and remain firmly committed for a period of time. Desired changes through new understandings will then occur. When implementing a program based on a new concept, as is this integrated child care program, it is important to monitor and evaluate the changes. This program uses staff checklists (described later in this section) administered at six month intervals to monitor changes in attitudes and practices. Annually, a survey regarding their feelings, perceptions and practices is used to examine the

changes in their understanding of the integrated program.

The program administrator needs to be familiar with what services are available for purchasing in the community. Decisions can be made based upon what services the program wants to offer. Then deciding on the staff person to fill a position depends upon the skills the program wants to see in that person.

Whatever choice the administrator makes about providing services, this program recommends the team approach. The team approach takes into consideration the talents and different perspectives of the different disciplines. The benefits to the program and to the children being served are (a) an increase in information to be used when planning for individual children, and (b) shared decision making and more efficient in problem solving. The constraints are having to consult each member in the team approach and the scheduling and coordination of services. It is the opinion of this program that the benefits outweigh the constraints.

Although the team approach has much to recommend it, it is not without its problems. The coordination of staff meetings can be a challenge. Staffing for this program occurs between 12:00 pm and 2:00 pm when children are napping. Each classroom staffs with the multidisciplinary team one hour every three weeks. The therapists, nurse and social worker are expected to participate in these meetings with teachers. Since there are eight classrooms, this means one-hour meetings three days a week for the interdisciplinary team. One day each week the full program staff meets for an hour. This requires careful planning to enable all persons to attend most of the staff meetings.

This program uses a rotation system in the naproom so that no person is responsible for spending every hour with chil-

dren throughout the day. This is an important consideration in a full-day program. The ways to address this issue are continually under consideration. The rotation system means that each teaching team and therapist has a responsibility for a rotation in the naproom during full staff meetings. This usually occurs once every few weeks. One of the teaching team members is always in attendance at staff meeting.

The staff meetings that occurs weekly for all staff is the minimum that this program would recommend. The staff agenda is posted on the wall prior to the meeting so staff members can add agenda items if they care to.

Staff meetings operate on a consensus model. If an item cannot be resolved, a volunteer committee is formed to collect information and report back at the next meeting. This consensus model is used with all major and minor issues. It is a very important element to emphasize with a new staff person. This model allows for the greatest input and responsibilities for the staff, particularly if there is a large staff.

In summarizing the strategies under method two, the following useful examples can be cited:

(a) Staffing patterns provide two teachers for each family unit of eight children. The team is comprised of a certificated special educator and an early childhood specialist. Therapists rotate in and out of the family unit groupings working with handicapped children individually and in small groups. They also monitor the physical and cognitive development of the normal children.

(b) The teaching staff rotates to one of three different shifts every three months to accommodate the 7:00 am to

5:30 pm hours of the program. These shifts run from 7:00 am to 3:00 pm, 8:30 am to 4:30 pm, and 9:00 am to 5:00 pm. The social worker responsible for home programming returns to the center by 5:00 each day. Both that person and the program director are responsible for the closing hour of the day. This closing hour strategy has several advantages. It builds credibility with other staff members because every one is working with children at least some part of the day. It allows the two persons who have had least child contact each day to have some contact. It resolves a difficult problem that exists in all child care programs (the "last hour of the day syndrome") and allows the program administrator to have daily experience with working procedures and systems. It has the advantage of weaving the staff positions more closely together. This appears to be the most suitable arrangement for a difficult time of the day.

Often, direct service persons have express how they feel justified in their "tiredness" at the close of the day because they know that two fresh persons will meet the parents and interact enthusiastically with the children.

Hours for the therapists, nurse and cooks are adjusted to correspond with the children for whom they are directly responsible.

(c) The educators are essentially the case managers of each of the eight children in their family unit.

(d) Lesson planning is the responsibility of the educators for each family unit of eight.

(e) Staffing to monitor individual program plans for each child and share assessment information occurs every

three weeks for each family unit and its team of educators.

(f) Peer group planning responsibilities are shared by all therapists and teachers. Planning sessions occur once every two weeks. Over the course of a year with each staff person rotates to a different peer group. This provides an opportunity for each staff person to work with almost everyone besides his/her own team member.

(g) Routines and schedules (i.e. naproom, aides, maintenance activities), are planned by the staff. They are quite creative in their use of classroom aides (in this program mentally disabled adults have been trained as aides) and in scheduling events for their days.

(h) Paperwork, data management and report writing occur primarily between the hours of 12 pm and 2:00 pm each day. It is misleading to presume that each day there are 2 hours available for this task. Because of staffings and other planned and unplanned events, usually only one hour per day is allocated to paper work. Assessments are usually performed with the child during classroom time.

Paperwork is always one of the most useful and the most controversial strategies for program documentation in this program. The issues of time, appropriateness, amount and necessity are continually problematic. Each problem solving session leads to more refinement of the procedures, resolution of the problem and an increased awareness of the fact that it will always be an issue in a full day program.

Again, the staff is reminded that within the constraints of our funding guidelines and program goals, the intention is to assess accurately, report objectively, plan accordingly and evaluate systematically for the individual child. They

are asked to problem solve the time issue and refine the process within these guidelines and constraints.

Staff Competencies

Much consideration has been given to the competencies of staff persons in this and other early childhood programs. Moving on to method three, that of identifying desirable competencies in staff persons working in an integrated or mainstreamed program, the strategies are as follows:

(1) Program administrator determines what staff positions are desirable to meet program goals (described under method two).

(2) Administrator identifies competencies needed by person in each position.

(3) Administrator hires persons with those competencies or plans for training in the needed skill areas for persons already working in the program.

For purposes of outlining those competencies, a most useful document is a recent publication entitled Basic Competencies for Personnel in Early Intervention Program: Guidelines for Development (Zeitlin, 1982). It was prepared by INTER-ACT, the National Committee for Services to Very Young Children and their Families.

These competencies are divided into five categories: (a) child development, (b) family involvement, (c) program implementation, (d) assessment and (e) administration. A brief description of each category is as follows:

(a) Child Development: Any person working with young children, handicapped or normally developing, needs a strong base of knowledge of both typical developmental patterns and atypical patterns of development. "Early interventionists (meaning any person working with young handicapped children, regardless of the training discipline) must regard young children with special developmental needs as unique individuals who have much in common with other young children and who also have their own particular strengths, difficulties and interests."

The need for knowledge of normal growth and developmental milestones became apparent when normal children began to be integrated into a program that had been only for children with special needs. It became apparent to staff persons that "normal" was a wide range of behaviors and the opportunity to observe these behaviors in the integrated setting increased the awareness of that knowledge base. The staff acquired more refined observational skills and continued to add to that knowledge base with increased time in the integrated setting.

(b) Family Involvement: "Except in unusual circumstances, parents are the most influential persons in their children's lives and are in the best position to determine their futures. It is therefore important that families be involved in every aspect of programming. To encourage this involvement, staff must communicate that they value family members as people and see their developments and accomplishments as worthy goals."

Competencies in this area are defined by this program as objective listening skills, knowledge of problem solving techniques, minimal knowledge of counseling skills by all and maximum knowledge level by at least

one or access to someone with higher level skills, awareness of community resources, behavior management techniques and the ability to communicate clearly and in a variety of methods to parents and caregivers.

(c) Program Implementation: "Program implementation may be the most publicly visible functions of the staff persons but it does not stand alone. Its effectiveness depends, in large part, on mastery of the other four competency areas. It requires counseling skills, sensitivity to child and family needs, familiarity with various types of evaluation and program philosophies and knowledge of current research and practices." Generally, in this program, it has been the responsibility of the program administrator to coordinate all of these elements. Staff continually needs to be aware that these responsibilities are those of the whole staff.

(d) Assessment: "For purposes of this program, the special educators and therapists need to be competent in the assessment process, both with informal procedures and formal protocol. Early Childhood teachers usually have an introduction to these procedures, and if they have not, arrangements for them to secure these competencies comes as a by-product of work with the other staff members, or through formal training in the center. Although each discipline brings to the assessment process its own well developed devices to assess the child, there are purposes and components common to all disciplines. These include eligibility determination, planning of intervention strategies, child progress evaluation and the assessment of parent needs and coping capabilities."

It is important to note here that these competencies are needed for an integrated and mainstreamed program

and are, in the opinion of this writer, needed for any program working with young children and their families. The staff of this program discovered early on that parents of normally developing children had as much need for parenting information, as many ambivalent feelings about their roles, as much misinformation and as many imagined and real problems as parents who have children with handicapping conditions.

(e) Administration: The competencies described in the INTER-ACT document are the same competencies this program identifies as useful and essential. "Competencies related to program philosophy, evaluation, community involvement, dissemination, staff relations, selection and training, fiscal management, legal and professional conduct and interpersonal management are all important for the program administrator."

It is the suggestion of this program that any program engaging in mainstreamed/integrated activities recognize that the larger society may not see the elements that become so usual and accepted to the program each day. Therefore, the staff, particularly the administrator, must plan for those elements and provide strategies that measure the effectiveness of the program.

In the INTER-ACT document, the areas of competencies described here are delineated further. It is the suggestion of this writer that the identified competencies become incorporated with the other skills checklists so that the program has a document of behaviorally-stated steps to acquiring those competencies. These competencies can also become the basis for individual development plans for each staff person.

Inservice Training Plan

This brings this text to the fourth method, that of identifying an ongoing training and in-service plan that will assist staff members in their growth and development. The strategies for this method are as follows:

(1) Identifying staff competencies in writing.

(2) Assessing the current level of staff persons.

(3) Outlining the assessment information and having each person design their own development plan.

(4) Establishing a routine for evaluating the development plan and recording growth and acquisition of skills.

(5) Outlining the above described steps as the in-service plan for group staff training.

In this program, each person has a personal development plan designed around an instrument called Skills Inventory For Teachers (Garland, 1978). The instrument suggests skills needed in categories (i.e. assessment, parent involvement, program planning). It provides a measurement plan by which one can determine if those skills are being acquired. That instrument is coupled with a written personal plan that includes goals the staff person wishes to accomplish and is projected on a 12 month timeline. This plan is the joint effort of the director and each staff person. It is designed to assist the staff person in objectively evaluating personal and professional growth during a year. It is the experience of this project that teaching and providing therapy is a very open ended process and that attention needs to be given to the sense of closure on the part of staff persons. In a 12 month program, coming to closure on a

portion of time is critical in assisting teachers and therapists in objectively viewing their work time.

It is of interest to note that when this procedure was first adopted, it seemed that it was looked upon as a chore to be accomplished. As the months progressed and the program developed, the staff began to regard this process as a useful measure of their own growth. Every 6 months the individual staff person meets with the program director for purposes of individual evaluation. At this time the staff person shares in writing his/her own assessment of his/her performance over the last 6 months. Together, they evaluate the Skills Checklist (both director and staff member compare evaluations), assesses personal goals and objectives and the director writes an individual performance evaluation.

The performance evaluation is logged into the employee personnel file and remains as a reference for future consideration for advancement, as well as potential employment outside of this program. Currently, each time the director and staff person meet to discuss performance, there is the expression on the part of the staff person that this method is useful. Coming to closure on personal goals and objectives and recording personal growth might not be given much thought. If not for this more formal approach it might not happen in the day to day activities. Every 12 months each staff person designs a new personal plan.

Staff Training Activities

Staff training is the fourth method of staff development. The strategy is to administer a staff needs assessment yearly. Based upon the results of the needs assessment, a staff inservice training plan is designed and implemented for the year. This program's plan is to have at each weekly all-staff meeting a presentation from an outside agency or

an inservice presented by a staff person. The current schedule is an outside presentation the first week of the month. The second week, there is a presentation by one team of therapists. The third week is kept a free week for more intense problem solving, and the fourth week includes a presentation from another staff person, usually teachers.

Though this may seem a bit structured in approach, this program finds that given the pressures of an all day program, this model of staff training is very useful and provides the staff with a feeling of accomplishment. In the day to day activities of a full day program this is an important point to consider. Professional persons working with infants and toddlers need training options to retain their professionalism and enthusiasm level.

Included in the staff training and inservice plan is the time management training. The first training was provided by a person hired to do that. At the beginning of the integrated program, all staff were instructed in time—management theory, principles, strategies and techniques. It is the opinion of this writer that the time management training was perhaps the most valuable training to have at the beginning this project. All staff began with a basic understanding of what time-management principles involved. Many misunderstandings were avoided because of the agreed upon basis on which all are operating. An example of this is, if someone is talking to another during a free time and one person is planning a work time, it is very acceptable to say "this is the time I've set aside to write and I really need to do it now, so let's set another time to talk." Good time management skills in the repertoire of all staff persons has contributed significantly to the success of delivering comprehensive services. In a full day program where traditionally time has been a reason for not providing assessments, report writing, staffing and other tasks, this program has found that time management is a way of

addressing this issue.

Another important issue this program finds necessary to address is the topic of stress management. Staff persons continue to find that the pressures of a full day program, the requirements of this program with regard to assessment and program planning and the development and implementation of an unfamiliar concept sometimes stretch each staff person's coping mechanisms. For the benefit of the program and the emotional well being of the staff, regular and systematic attention needs to be given to this issue. This can be in the form of staff training through inservice, personal development of individual staff members and critical attention to the daily environment. Collectively, the staff in this program continues to seek positive ways to make the daily environment more relaxed and supportive of the individual and group needs of the entire staff. A useful tool in addressing this issue is a recent book, The Special Educator: Stress and Survival (Deshon, 1981). Though the book focuses on the special education environment, the principles and practices are useful and the book presents practical bits of information for any staff in an early childhood setting. At regular intervals, the staff focuses on particular chapters and discusses the issues raised in that chapter. This approach seems to be useful and instrumental in acknowledging and addressing the problem. When synthesizing information for purposes of writing this manual, staff concluded that training needs to be in the form of:

Presentations by outside speakers as well as by staff members with special skills; professional leave to observe other programs; having current articles and research information on a wide range of topics; having observations of the staff routinely performed by other professionals for purposes of feedback; and a clearly identified decision making and problem solving system within the program that has functional mechanisms which contribute to resolution of

problems. This program attempts to answer these needs through the activities described in this chapter.

EVALUATION

The staff training component must relate to all other program goals. In order to evaluate the component, it needs to be clear what is being evaluated. In this program, the elements to be evaluated are the skills needed by persons working in an integrated program; the competency levels needed by each person; evaluation of training of each person and how that contributes to personal growth.

A needs assessment is administered to all the staff on a yearly basis relative to the evalation design. This assessment is based on a discrepancy model (Brookfield, 1981), and is designed to determine what level of information the staff currently possesses and what information each needs to acquire to reach the level of skills required in the program. Based upon information from the needs assessment, the entire staff lists in order of priority their needs for training. The program manager and/or a small group who volunteers to assist then identify the persons or resources to provide that training.

The instrument, Skills Inventory for Teachers, becomes a measure by which each person evaluates her/his personal growth. Another measure is the personal goals and objectives that each person designs for her/himself. These are projected on a 12 month timeline, and a mid-year evaluation occurs to monitor progress toward the goals. This personnel development plan is designed by the individual staff persons and program director. The areas to be included are usually personal, programmatic and professional development. Coupled with the Skills checklist, which includes 6 skill areas, this development plan provides a useful measure of how each person is progressing over a period of a year.

An evaluation format designed to assess the usefulness of inservice and professional training is in the form of a one page questionnaire with numerical ratings assigned to the questions. After each event, the participating person evaluates the training from her/his own perspective. At the end of the year, the results are tabulated and synthesized and a report is discussed with staff so that they have benefit of that information for purposes of implementing changes and planning for the next year.

Staff also evaluates specific program components. For example, when evaluating the inclusion of all handicapping conditions into each classroom, the surprising consensus was that the staff really preferred having a wide range of handicapping conditions represented in the program. The same opinion is held with regard to handicapping conditions in the classroom. Apparently, a wide range of handicapping conditions challenges the staff and provides an increased knowledge base. They indicated their experience had shown that no child was slighted in attention and, in fact, all benefited from the arrangement. Had we relied only on the literature or existing practices and opinions we might not have continued this arrangement. This example is cited to convey how information is used to refine the program procedures and practices. Staff members evaluate components of the program at different checkpoints during the year and at different stages of program development.

Every six months, the program manager writes an evaluation of the performance of each staff person. This evaluation is written after meeting with each person, going over their skills checklist, their personal program plan and discussing observations by the manager during the period. The evaluation is written based upon this information. It specifies the areas the manager would like to see developed during the next 6 months as well as the areas which the staff person would like to see developed. The director of the agency

goes through this same process with the program manager.

The procedures used for staff evaluation in this program are refined each year. New staff persons also bring information that helps the program to refine its procedures. The systems described in this chapter are useful in this full day program.

BUDGET CONSIDERATIONS

Costs for staff development are surprisingly minimal in this program. Budget items include a monthly allocation for conference fees. This budgeted amount is helpful in providing each staff person with financial assistance for attending conference activities. It is expected that each staff person will attend a minimum of one conference a year.

Inservice training provided by outside consultants costs little. This program is engaged in reciprocal agreements with local colleges, universities, agencies and individuals so that information and training is exchanged frequently. In return, this program provides similar services to other programs.

More money allocated for staff training is always desirable and useful, but staff training can exist on a shoestring. Usually, that means thoughtful and creative planning on the part of the staff and program manager. When little money exists for training, no strategies or ideas are ignored.

It is important to budget money for substitute teachers. This is especially important in a full day program. One year staff presented the director with a suggestions regarding substitutes. They would be willing to cut back on more equipment in order to have adequate money for substitutes. This suggestion was honored. Since it was a decision formed from consensus, all staff members accepted the decision all year.

Budgeted amounts for staff training are among the least considered items in many program budgets. This item should receive more consideration in new program development. Even though money may not be available for staff training, creative strategies can be implemented to acquire the needed

training.

METHODS SUMMARY

The five most important points to consider in this staff training and development section are the following:

(1) Clearly identifying program goals and objectives and articulating them to staff at regularly scheduled intervals.

(2) Determining what staff is necessary to accomplish those goals. Decide if they will be hired or if their services obtained through contract or other arrangement.

(3) Determining the characteristics and competencies desired in staff members and what training is needed to assure those competencies.

(4) Establishing an ongoing training plan with some method for evaluation so staff can know the plan is working. The plan needs to include methods for staff input and decision making, strategies for coming to closure and strategies for insuring that staff continues to feel professional and experience professional growth and development.

(5) Listening to the staff and designing staff training plans around the staff needs. The program administrator needs to feel comfortable in including what he/she feels is needed for the development of the program aan[the individuals. A combination of both perspectives is needed for the staff to confidently use their skills and provide better services to young children and their parents in the integrated program.

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Chapter X

TRANSITION PROCEDURES IN AN INTEGRATED OR MAINSTREAMED EARLY CHILDHOOD PROGRAM

RATIONALE

Parents of infants and toddlers who have a positive first experience with an out-of-home program need assistance when it's time to leave the program. This program needs to acknowledge that this condition will exist and plan for transitions before they occur. The purpose of this chapter is to focus on activities that make the transition from one program to another easier for staff, parents, children and the personnel in the receiving program.

METHODS OF ESTABLISHING TRANSITION PROCEDURES

The first step is to make transition procedures and activities consistent with the program goals. For example, if a program goal is to encourage independence in decision making in parents, then it would be inconsistent with program goals for the staff to assume all of the responsibility for program selection.

The second step is to assist the parents in acting as advocates for their child. Whether the child leaving this program has a handicapping condition or is normally developing, the parent is going to be confronted with years of exploring options for their child's program. This is especially true if they continue to work outside of the home.

For the parent, knowing what she wants for her child's program is part of becoming an advocate. This includes learning what is available in alternative programs. Alternative programs can be in the form of special programming in school districts, child care arrangements after specialized programming or all day child care. These are considerations for the family of a handicapped child. Parents of a normally developing child are confronted sith similar considerations for child care, at least until the child enters elementary school.

Statistics in most communities confirm the increase of working parents with children under six years of age. Parents have an urgent need for information about getting the child care they want for their children. This is a particularly urgent need for parents of children who are handicapped because there are so few child care programs providing such services. The parent then has to determine if those services are appropriate for her child.

A third step is establishing procedures that work for the parents and staff. Ways to do this will be described in the following section on Strategies.

STRATEGIES FOR INTERVENTION

In describing strategies to support the first step, that of establisheing procedures consistent with program goals, this program defines the transition procedures as being a part of the whole program. In looking at the program on a time line, and determining of what the program wants to accomplish during the year, the transition procedures are an important part of the program goals. This is important. Frequently, the transition activities that take a child and family from one program to another are not clearly conceptualized or communicated to the parents. So, the transition procedures become high priority program activities.

In this program, children leave when they are age appropriate for public school special education programs if they are handicapped. Public schools begin providing services to young handicapped children at age 36 months. This occurs in most districts in the State of Washington although such services are not mandated.

If children are normally developing, the age they must leave is 40 months. The transition occurs in September of a regular public school year. In this state, if a handicapped child becomes 36 months after August 31, then the child can remain with the program until the following school year. This program's license to provide child care services is from 4 to 40 months. For a child to remain any longer, an exception to policy is required from the state agency responsible for licensing child care centers. Usually no requests for exception occur, as services become more available for children chronologically above 40 monthes. Sometimes, a parent of a handicapped child who is developmentally below 40 months will ask for their child to remain for another year. Depending upon the space available, the families needs and their ability to pay for services, such a

request is considered. Since the handicapped child is no longer funded for services beyond 36 months, the parent must accept services provided through the school district or pay for them privately.

The next strategy is for the staff to conceptualize the transition events into workable activities. In this program, it is considered important that families accept a major role in this process. So, every event is designed from the perspective and with the expectation that families will perform the tasks and complete the activities. This means that whenever possible, parents are included in the planning so they know what to do. Staff is always ready with assistance and encouragement. This is a difficult time because it is the first experience for families in leaving a program.

When staff conceptualizes the transition plans, care is given to defining who is responsible for what activity, when it will occur, and what is required to complete the activity. Expectations of the receiving agency are also considered. Any other criteria contributing to a smooth transition are considered. In this program, the goal for the transition process is to assist the parents in identifying what they want for their child and to understand what they will have to do to accomplish. The staff assists them when they discover how they may have to compromise when options are not available to them. In this program's opinion, this is a very important message to be communicated to the parents. They need help in knowing how to identify what they want when choosing a program. They need to know how to balance what they want with what exists. Helping parents to identify their parenting style, parenting philosophy, values and goals for their child is useful in sorting out these complicated issues. Through conferencing, the staff discusses these issues and shares their own perceptions about the child. They offer information about

future programs for the child. They often visit prospective programs together.

The second step, that of assisting the parents to become advocates for their child, is accomplished by the following strategies:

(1) The Family Services Specialist gathers all of the available information on programs that are options for children leaving this program. That information is discussed at the weekly all staff meetings and the weekly individral team staffings.

(2) The multidisciplinary team, with the teachers acting as case managers (as described in staff training chapter), then begins to disseminate information to the parents of individual children. The dissseminated information is delivered within the context of what the staff see as good possibilities for the child. Often the staff has been working with that child for a long period of time, so their perceptions are valuable and helpful. Parents appreciate the objectivity of their information. The parents are encouraged to make decisions that are compatible with their desires for their child and their lifestyle. Although this may sound idealistic, it is the point from which the multidisciplinary team begins with the parents. As might be expected, there is much negotiation from that point forward.

(3) The Family Services Specialist, teachers and therapists assist the parents in formulating a plan for their child that is an ideal plan, then work with the realities of what exists.

A third step in planning is in establishing procedures that work for both parents and staff. Following are some procedures that work in this program.

(a) The Family Services Coordinator organizes all available information into a "transition packet" to be distributed to parents whose children are leaving in the Fall of the program year. The packet includes a letter of description of events, a brief description of all programs for which their child might be eligible, tour days of the prospective programs and contact persons at the program sites. Step by step procedures are stated. This information is compiled by the staff.

(b) After 2 weeks of having time to think about the information, the Family Services Coordinator or teachers contact the family to see if any action is being taken. At this time, the staff begins to formulate ideas about what assistance the family will need. These same procedures are followed for children who are normally developing, as well as children who are handicapped.

(c) Discussions occur in the multidisciplinary team meetings about how each team member perceives the child's needs being met through the available options. Individual team members are assigned responsibility for collecting information that will be needed for making decisions about the future placement.

(d) In April of the program year, the evening parent meeting is devoted to a panel discussion. The participants are representatives of the various programs a child might enter in the next program placement. Panel participants usually include representatives from local school district programs, child care programs, other early childhood programs, and Head Start. The intent is to provide enough information from as wide a range of representatives as is possible. Concurrent with this event, the staff is engaging in a decision-making process with the family. Ultimately, a decision will

be made.

(e) Following the April parent meeting, a time is scheduled with the multidisciplinary team and family members to discuss program options. At that time, current child asssment information is discussed and anxieties of parents are addressed. At this time the plan for transition is confirmed.

(f) During May or June, the Family Services Coordinator arranges with the parents a time for tours of the available programs. The staff provides written and objective criteria regarding program selection. This is an important time. These tours and the written information provide the parent with the information she needs for final program selection.

(g) Following a tentative program selection, the next step is to find out what information the receiving program will want. The Northwest Center staff, the prospective program staff and the family clarify what procedures will be followed by all persons. Timelines for action and activities are established and responsibilities are assigned to appropriate individuals.

A month before the child leaves the program a conference is held with the multidisciplinary team and the family. The purpose is to complete discussions regarding the child's individual program plan. Parent signatures are obtained on all information that is sent to the receiving program. Together, they examine all current information about the child and prepare materials to be sent. Usually this includes current assessment information, written classroom narratives, therapy reports and any other information that is designated as helpful by the receiving agency. The Family Services Coordinator compiles a checklist of all activities for each child who is leaving the program. She

is the person responsible for checking off each task on the list. All written information is sent to the receiving agency by August.

Procedures for transition used in this program are modeled after the Single Portal Entry Project (Edgar et al., 1982). This model suggests methods for providing a smooth transition process in a program. This program finds these procedures in the Single Portal to be most useful for planning. This program would recommend the model to other programs.

EVALUATION

The evaluation of the transition procedures occurs at least once a year. Information is obtained through a brief staff questionnaire, a parent questionnaire, a final evaluation form and through discussions with staff. Consensus determines what changes will be made after reviewing all evaluation information. Information on school district procedures is critical to this process. Since these procedures change frequently it is important to maintain up-to-date data and good relationships.

This program finds it important to have a firm framework for the transition process, refine that process during the year, and then make changes as needed. With parents, staff, school districts and private child-care programs to consider, the changes can be overwhelming from year to year. A basic framework is essential but this must be flexible in order to relate to external program changes.

It is strongly recommended that evaluation checklists used by staff and parents be short and simple. This helps everyone to have a better idea of the changes that need to occur and the reasons for them.

Evaluation for transition is loosely based on the following criteria:

(1) Age appropriateness of the child.

(2) Absence or presence of handicapping condition.

(3) Parent and caregiver desires, based upon their perceived needs, child needs and what they want for their child.

(4) Northwest Center multidisciplinary team assessments of which program would best answer the child's needs from all available options.

(5) Synthesis of all available information into a comprehensive transition plan for the child and family.

Again, it is important for this program that the transition procedures and the evaluation of these procedures relate to the overall program goals and objectives.

BUDGET CONSIDERATIONS

Thera are no particular budget constraints to consider when assessing the transition procedures, other than the time allocated to staff activities. These activities need to be evaluated with reference to cost efficiency. For example, is it more cost efficient for teachers, therapists, the Family Services Coordinator, or other persons to take the time to accompany parents to the program options as providing information only? Again, these have to be weighed against program goals. In this program, we try to be flexible and to use each person's time wisely. The person generally gathering information with time allocated to these activities is the Family Services Coordinator. However, this means time away from home programming while some of these activities take place.

If teachers or therapists take time away from their classroom or sessions to accompany parents to visit programs, then a teacher substitute must be included in the program budget. Factors other than cost must be considered. Teachers like to accompany parents of children in their rooms to visit program options so they might observe the programs. Since these teachers have considerable knowledge about these children their observations are particularly valuable in helping parents reach appropriate decisions.

The administrator of this program evaluates the cost efficiency and effectiveness of each request and relates these back to the person making the request. Ultimately, such requests are reflected back to program goals and compromise and negotiation are possible.

This program is fortunate in not having to budget for in-service training in the transition process. The staff of the Single Portal project provide this service without cost.

However, in-service training in the transition process is helpful and must normally be budgeted for. This is a difficult area to obtain help through the exchange of personnel but if it can be done, it not only enhances the program but saves money. Personnel exchanges also serve a valuable networking function.

METHODS SUMMARY

The five most important points to consider in planning for program transition are as follows:

(1) Transition activities need to be consistent with overall program goals in their implementation.

(2) There needs to be very clearly established lines of communication and responsibilities, complete with who does what and when, and on what timeline.

(3) Program change usually means a change from one service delivery system to another, so it is vitally important to have all information, including procedures, guidelines and costs related to the different systems.

(4) Staff and parents need to prepare for the changes in a systematic way that recognizes that any change is difficult. Plans for coping should be included in the overall design.

(5) Philosophical considerations need to be examined. The transition activities need to be a part of the educational process of any program.

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Chapter XI

SUMMARY

This manual describes the various components that appear to make this program unique. Three years later, this program concludes that all infants and toddlers served outside the home deserve no less than the quality of services described in this manual.

A great deal of commitment from the staff, as well as from this fiscal agency, has gone into implementing these services. This program remains committed to the concepts and comprehensive services provided. Our challenge will be to make use of some of the alternative strategies described in the previous chapters as portions of our own funding come to closure. This program will then be in a position to implement some of these previously described budget options.

This program feels confident that the information it has acquired is so valuable that it will continue to serve as guidelines for the program. The information will be reviewed and refined as necessary in the years to come. The procedures followed by this program are often the ideal, largely because of the professional training of the staff and the high ratio of staff adults to children. This program strives to keep this ideal within reach, while always compromising with that which is reality.

It is the hope of the persons who have participated in this project that the vision of the ideal will always provide guidelines for any changes. With the rich staff ratio, we have observed how the quality of services has improved this

program. With the objective assessments and reporting, we have documented the child and family changes that have occurred while they have been a part of our program. With the follow-up information on children who have been in this program, we can document the manner in which people generalize this information to other educational and community environments.

The information gathered through this demonstration project equips us with data that indicate to us the following: not only where we go from here, and how we will progress, but also that we have a sense of urgency in doing so. The children and families for whom these services are designed are the building blocks of the future, yours and ours. They deserve the services that will provide them with the skills, vision, and information with which to shape the future. Their services now depend on all of us. Our futures depend on all of them.

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